

A LEARNING NEEDS ASSESSMENT OF PARISH NURSES

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Abstract

Parish Nursing is relatively new, having its original Scope and Standards from the American Nurses Association published in 1998. At the same time the Basic Preparation Curriculum for Parish Nursing, which had been developed through the International Parish Nurse Resource Center, was distributed to Educational Partners of the Center and used for Parish Nurse instruction. This curriculum has subsequently been revised in 2004 and 2009, but over this time a study of the learning needs of novice Parish Nurses has not been documented. This study is an assessment of the learning needs of one group of Parish Nurses. The study was constructed on 11 prioritized Parish Nursing skills from the “Getting Started” module of the Basic Preparation Curriculum for Parish Nursing and consisted of three questions about each skill. Survey respondents were asked to rank 1) the importance of the skill, 2) the percentage of new Parish Nurses whom they felt were deficient in the skill and 3) how important it was to add more training for that skill in the Parish Nurse course. Answers to the skill questions utilized a six point Likert scale.

Among other biographical information, respondents were asked how many years they had been an active Parish Nurse and to rank themselves based on Benner’s (1984) levels of expertise. Although the outcomes of the study are focused on the learning needs of novice Parish Nurses, input was obtained from Parish Nurses of all levels of expertise.

A qualitative component was obtained from the textbox at the end of each set of the three skill questions. The comments gave voice to the respondents and enriched the findings.

The study affirmed that the skill of 'Keeping Confidentiality' was unanimously rated highly and well done, but this is an essential skill to all nursing. The most variance came with the skill of 'Making a Budget'. Many Parish Nurses volunteer their services to their church, often with a 'zero' budget to work with, so making a budget is immaterial. The study showed that respondents in general were satisfied with their Parish Nursing training and that of their novice colleagues.

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Chapter 1 Introduction

Role transition in any instance is laden with stresses, both positive and negative. In addition, those who are in the midst of learning a new role experience a heightened perception of unfulfilled learning needs. The novice in a new role is inescapably confronted with the reality of what they know and what they do not know. Any plan to address unmet learning needs must first ascertain a clear account of what is perceived as unfulfilled learning needs before proceeding.

It is therefore most appropriate to validate learning needs by means of a needs assessment specific to the population in question. Best practice for a needs assessment entails pursuing, as directly as possible, the true voices of the learners, speaking on their own behalf. Seeking out the perceived learning needs not only enhances the personal satisfaction of the learners but also responds to a more serious need, the need to increase retention of novices.

Most learning needs assessments are impacted by various factors that may impede their success. Sometimes the learning needs are not fully obvious at the onset, but are, instead, realized over time. Sometimes the needs are better articulated with prompts to assist in recall, which may have the added advantage of preventing unreported oversights and standardizing the data gathered. Further, learning needs change over time and between different groups of like learners, so it is advisable to make assessments at regular intervals. This study is an initial assessment of the

perceived learning needs of Registered Nurses (RN's) who are new to the role of being a Parish Nurse.

Background

Parish Nursing is a relatively new concept in nursing, having been recognized as a subspecialty of Nursing since 1998 by the American Nurses Association and Health Ministries Association (Hickman, 2006). Current estimates of the number of practicing Parish Nurses in the United States range from 7,000 – 10,000 (International Parish Nurse Resource Center, 2008).

Parish Nurses are registered nurses who typically work in a faith community, such as a church or synagogue. The work of Parish Nurses focuses on the care of the whole person, emphasizing wellness of body, mind, and spirit (International Parish Nurse Resource Center, 2008). The care of the whole person is especially what draws many nurses into Parish Nursing, despite the fact that most Parish Nurses are unpaid volunteers. The Solari-Twadell (2002) study found that 67.9% of the respondents ($n = 1161$) nationwide were not paid. With this in mind, many nurses refer to their Parish Nursing work as a *ministry*.

The most common training for Parish Nurses is the 35 hour Basic Preparation Curriculum for Parish Nursing available through the International Parish Nurse Resource Center (IPNRC) in St. Louis, MO. IPNRC has more than 130 Educational Partners across the United States, who offer Parish Nursing training utilizing this curriculum. The Basic Preparation is not intended to be comprehensive, but a core introductory course. It has

not been evaluated as to how well novice Parish Nurses feel they are prepared after having taken the course.

For ten years now, the Basic Preparation Curriculum for Parish Nursing has been formally available through the IPNRC and is commonly used. The Educational partners utilizing the IPNRC curriculum may occasional do a learning needs assessment for local nurses, but a widespread assessment has not be done. It is most appropriate that an assessment be done to validate the effectiveness of the IPNRC curriculum and to plan for future classes.

This Parish Nursing Learning needs assessment canvassed Parish Nurses in Indiana who had completed a formal Parish Nurse training course and who were in various stages of developing a Parish Nurse ministry. As mentioned earlier, novices are not always in the best position to state their learning needs, as these needs may be realized over time. In this study, the expertise of the respondents ranged from the very newest novice with less than one month of experience to the 13-year-expert. This online survey assessment ascertained prioritized responses based on a six point Likert scale, along with strategically placed text boxes. A design such as this cues the respondents, preventing oversight of important skills, and yet inviting unconditional comments. The input of experienced Parish Nurses from all points on the continuum of novice to expert adds to the validity of the data.

The role of being a new Parish Nurse can be stressful and overwhelming, even if the nurse has several years of experience as an RN. In addition, potential Parish Nurses learn about Parish Nursing by hearing or reading about the concept, rather than the

more desirable observation of a Parish Nurse in practice. This unfamiliarity with the role, along with working as the lone Parish Nurse in a church, poses risks for any novice Parish Nurse. Therefore, making an assessment of the learning needs of novice Parish Nurses is an important step in assuring the success and retention of new Parish Nurses.

Purpose of the Study

The focus of this study examined the learning needs of novice Parish Nurses, who had completed a Basic Parish Nurse Preparation course and were on the threshold of establishing a Parish Nursing ministry. Specifically, this descriptive study sought to verify what priority skills Parish Nurses perceived to be needed in order to become successful Parish Nurses. Knowing the learning needs of Parish Nurses provides validation of what is being done well and informs educators of needed curriculum improvements for Parish Nursing education programs.

This study is important in clarifying what are the perceived learning needs of novice Parish Nurses during the crucial time when the new Parish Nurse is establishing a Parish Nurse ministry. The study is focused on this time frame, since this is the time of transitioning from learning to the application of what is learned. Survey respondents were Parish Nurses with varying lengths of time since completing their Parish Nursing training and with varying degrees of success in initiating a Parish Nurse ministry. The survey questions provided cues to the respondents, but text boxes with each Parish Nursing skill also solicited open comments from the respondents. Now that this study has been done, it will be easier to assess the needs of other groups and future groups of

Parish Nurses. In addition, comparisons and contrasts can also be studied over time and between various groups.

Research Questions

The study explored the following research questions:

1. What skills do Parish Nurses perceive as important in starting up a Parish Nurse ministry?
2. Which skills do Parish Nurses perceive as most deficient in novice Parish Nurses who have completed a Parish Nursing Preparation course?
3. What skills do Parish Nurses perceive as important for Parish Nurse training to develop further?

Conceptual Framework

In the early 1980's Patricia Benner (1984) developed a novice-to-expert model of nursing practice which was built on the Dreyfus model of skill acquisition.

Stuart Dreyfus, a mathematician and system analyst, and Hubert Dreyfus, a philosopher, have developed a model of skill acquisition based upon the study of chess players and airline pilots. The Dreyfus model posits that in the acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These different levels reflect changes in three general aspects of skilled performance. One is a movement from reliance on abstract principles to the use of past concrete

experience as paradigms. The second is a change in the learner's perception of the demand situation, in which the situation is seen less and less as a compilation of equally relevant bits, and more and more as a complete whole in which only certain parts are relevant. The third is a passage from *detached* observer to *involved* performer. The performer no longer stands outside the situation but is now engaged *in* the situation. (p. 13)

Benner's (1984) work was based on a qualitative review of more than 100 interviews and observations in which nurses shared exemplars (or narratives) of their work. Benner promoted the use of narratives to tell the stories of professional nurses working at each level of the Dreyfus model. For Benner, personal experience affects the development and complexity of the nurse's base of knowledge. Benner's novice-to-expert framework utilizes the same five stages of professional growth: (1) novice, (2) advanced beginner, (3) competent, (4) proficient, and (5) expert. To ascertain the differences in the clinical judgments of the novice and the expert nurse, Benner interviewed 21 pairs of beginners who had been matched with nurses who were recognized for their expertise. Each member of these pairs was interviewed separately about the same patient care situation; a situation that stood out to both of them. In addition, interviews and participant observations were conducted with 51 experienced nurse clinicians, 11 newly graduated nurses and five senior nursing students, as a means to further delineate characteristics at these different stages of skill performance. Before the interviews, participants were given an outline of questions about their own "critical

incidents” that they would discuss. In her book, Benner (1984) writes this was an unfortunate label, as the nurses reported situations of gravely ill patients. The researchers had to explain that other significant, high level incidents were also wanted. Neither the Dreyfus brothers nor Benner, were looking for a renaissance person who could perform well under any circumstance. Instead they were seeking to identify ‘meaning and content’ in the dynamic transaction between the performer’s knowledge and the situation in which they were immersed. The inexperienced beginner ‘sticks by the rules’ because that is all they have to go by. Their performance is halting and rigid. A typical assumption is that these governing rules become unconscious with repeated performance, i.e., experience. In the Dreyfus Air Force studies, they questioned this paradigm: Did the pilot instructors apply the rules more quickly and more accurately than the student? By measuring eye movements, they “found that the instructors weren’t using the rules that they were instructing the trainees in at all!” Ironically, by deviating from the rules, the instructors performed faster and better. Further, if pilots and other experts were forced to adhere to the rules and guidelines that they used as beginners, their performance would actually deteriorate (Benner, 1984, p. 38)

Benner identified the characteristics of each level of skill and discussed facilitation of growth within each level by utilizing the narratives of both the experienced and inexperienced nurses. Nursing knowledge is gained over time and in such a subtle way, that often the nurses themselves are unaware of their gains. They can share the rationale for their decisions, but it is usually situation specific. That’s what

makes it so difficult; few situations are exactly the same. Nurses who have weathered the ups and downs of their practice have a lot to share with the novice practitioner. These 'expert' nurses "uncover common meanings acquired as a result of helping, coaching, and intervening in the significantly human events that comprise the art and science of nursing" (Benner, 1984, p. 12).

Parish Nursing is a unique form of nursing. Most Parish Nurse Basic Education courses prefer that the nurse participant has at least three years of experience in Medical-Surgical or Community/Public Health Nursing prior to taking the class. As a Parish Nurse goes through the basic education and embarks on starting the ministry, she/he does not have to be trained to be a nurse, but does need to be trained in initiating a Parish Nursing ministry. This is something the nurse has very likely never done before. The conceptual framework of novice to expert is especially fitting for the assessment of learning needs of novice Parish Nurses. The experienced Parish Nurse is well past adhering to the rules and now banks on her experience to make decisions. Conversely, the novice relies heavily on the rules and guidelines to make decisions. Are the opinions of these two groups different in regard to the learning needs of the beginning Parish Nurse? There were some differences as would be expected, but this study validates that Parish Nurses hold similar opinions along the continuum of novice to expert regarding the learning needs of novice Parish Nurses.

An additional supportive framework for this study is the *accountability process* proposed by Berardinelli and Burrows (Vella, Berardinelli, & Burrows, 1998). The

accountability process was “developed after an extensive review of research and theory supporting effective learning and evaluation procedures” (Vella et al., 1998, p. 20). The framework consists of six elements, each flowing from the previous one, based on the results expected from an education or training program. Program evaluation measures the effectiveness of the elements and the inter-relationship of these elements. The six elements of the *accountability process* include:

- Purpose of the education program
- Learner skills, knowledge and attitudes to be developed
- Education program design decisions
- Learning that occurs in the program (*Learning*)
- Changes in job performance (*Transfer*)
- Organizational improvement resulting from the education program (*Impact*)

Learning is defined as changes in the learners’ knowledge, skills, and attitudes that result from the program. *Transfer* is learning from the program that is applied in the learner’s work after completing the education or training program. *Impact* is the improvement in the performance of the learner’s organization as a result of the learner’s work. Each of these results is independent, but also shares a relevant connection to the others. For example, without the educational program, the learners do not change and there is no application of the learning to their performance, and if

the learning is not taken back to the organization and used there, then the organization has not benefited from the learner having attended the educational program.

Ideally, evaluation is embedded in program planning, but these theorists realize that evaluation many times takes place after the program has been developed and presented. This is the case for the Basic Preparation Curriculum for Parish Nursing. The curriculum has been available and taught by IPNRC's educational partners since 1998, and many Parish Nurses have gone on to successfully establish a Parish Nurse ministry in their chosen faith community. In the author's experience, there seems to be about a 50% success rate.

Just as Parish Nursing is new for the nurse, albeit desirable, it is also new and unfamiliar for many faith communities. The unfamiliarity for the nurse, the clergy, and the faith community poses risks that include learning needs during the transition time while the Parish Nursing ministry is being established. This is the window, while the Parish Nurse Ministry is getting underway, during which the transfer of knowledge from the Preparation Course is applied by the novice Parish Nurse. This is the time of much uncertainty, but it is also the time when success or failure takes hold for the novice Parish Nurse. Parish Nurse Educators desire success for the novice Parish Nurse and continually seek best educational practice outcomes. This study explored the learning needs of the novice Parish Nurse during this crucial time of establishing a Parish Nurse ministry.

Definition of Terms

The following definitions apply to these terms as used throughout this document.

- Learning need is a discrepancy between what individuals know and can do and what they need to know and do to achieve a higher level of performance (Copper, 1983, p. 33).
- Needs assessment is a “systemic process for collecting and analyzing information about the educational needs of individuals or organizations...[that] identifies discrepancies to be addressed educationally and measures the discrepancy between current and desired competence” (Adelson, Manolakas, & Moore, 1985, p. 16).
- Parish Nurse is a professional registered nurse (RN) who serves as a member of the ministry staff of a faith community, and whose role is the spiritual care-giving and promotion of health and wholeness within the context of the values, beliefs and practices of that faith community (O’Brien, 2003).
- Parish Nursing Ministry is a nursing practice within a faith community. In collaboration with pastoral staff and the congregation, the nurse works to accomplish the church’s mission of health and spiritual care. Through partnership and networking with community resources, the nurse promotes health and disease prevention for individuals and the faith community as a whole (International Parish Nurse Resource Center, 2008).

Limitations of the Study

The findings of this study apply to only those studied, specifically the Parish Nurse respondents in Indiana who had completed a basic Parish Nursing preparation course. The Parish Nurses were in the various stages of setting up a Parish Nursing ministry, including some who have tried and not experienced success. Although the findings were taken from a spectrum of Parish Nurses who self-ranked from novice to expert levels of proficiency, the results are inherently limited to a single geographic location, the state of Indiana and specifically those Parish Nurses who chose to respond to the online survey. In addition, with assessment data being very time limited, it is not safe to assume that later cohorts will have the same needs as determined by initial assessment (Kasprisin & Single, 2005).

Admittedly, investigator's bias may exist, but it was hopefully controlled by the investigator having taught Parish Nursing for more than ten years and by having evaluated student performance behaviors as faculty for a school of nursing. Every effort was made to maintain objectivity in the research process. Even so, some degree of non-control exists.

The study represents the work of the author and does not in any way represent the International Parish Nurse Resource Center, Indiana Center for Parish Nursing, any faith community, or the investigator's employer.

Chapter 2 Review of the Literature

Focus of This Review

This review of literature focuses on the origin of Parish Nursing and relevant writings of assessment outcomes and survey development.

Origin of Parish Nursing

Parish Nursing is a concept developed by the late Reverend Granger Westberg in Chicago. In the late 1960's, Westberg had experienced first hand the functioning of the "wholistic" health centers that were located in neighborhood churches across the country (Tubesing, 1977). The "wholistic" centers were experimental doctor's offices for family practice which were staffed by "spiritually oriented family doctors, nurses, and clergy" and financed by a Kellogg grant (Westberg, 1999). Throughout a ten year period, evaluators concluded that the quality of care under these conditions was indeed more wholistic care of the person. Closer examination as to the key factor in the success of the clinics led to the discovery that the nurse's role was absolutely essential. Nurses functioning in these church health centers interpreted two languages for the patient, the language of medicine and the language of religion.

With the closure of the wholistic health centers and armed with this discovery about the nurses' dual role capabilities, Westberg approached Lutheran General Hospital in 1984 about a less expensive option of establishing a 'nurse in the church'. In

the Lutheran religion, churches are referred to as parishes and thus the concept of “Parish Nurse” was fashioned.

Westberg worked through various levels of church hierarchies and ‘would be’ stakeholders, promoting the concept of a nurse on the staff of the church who would work for the physical and spiritual wellness of members of the congregation. Generally he was well received and in many cases enthusiastically received. Westberg (1999) writes that pastors “readily recognized that the nurse would be a person to assist them in their ministry to people who were hurting and many whom they felt they could not adequately serve by themselves.” (p. 36)

Throughout Westberg’s campaign to promote his idea of a nurse as a church staff member, the concept was regarded positively until the financial aspect was addressed. Financial solvency is a perpetual challenge of most churches and to introduce a staff position, especially a professional, is a real shock to the church budget. Westberg and Lutheran General Hospital worked out a plan where in the first year the hospital paid 75% and the church paid 25% of the nurse’s pay; the second year it was 50/50; the third year the church paid 75% and the hospital paid 25%; and finally in the fourth year, the church paid 100% of the Parish Nurse’s salary. To this day, most nurses who approach their church about establishing a Parish Nurse ministry meet with the same challenge as did Westberg. The ‘church-hospital’ relationship that assisted Westberg’s early work in establishing Parish Nursing is seldom available to today’s Parish Nurses. Hence, as stated above, these very dedicated nurses in the church proceed as unpaid volunteers and many are not regarded as part of the church staff.

Assessment Values

After completion of the Basic Preparation Curriculum for Parish Nursing, it is hoped that the course participant will go on to successfully establish a Parish Nursing ministry in a faith community. This process is new to the novice Parish Nurse who has likely not even observed another RN function in the role of a Parish Nurse. Although well-intentioned, new Parish Nurses are embarking on a role that is unfamiliar to themselves as well as their chosen faith community. As DeSilets (2007) states, “When individuals change roles, learning needs are automatically created” (p. 108). DeSilets further points out that continuing professional education may be in order for novices, but it must be developed with their genuine needs in mind. It is far more appropriate for program planners to seek out the unique learning needs of the target audience rather than rely on hunches. Learner input is not a luxury, but a necessity (DeSilets, 2006).

Defining the need begins with identifying the gap between where the learner’s knowledge is and where it needs to be. DeSilets (2006) calls this gap analysis, or the difference between what is and what should be. Traditionally, the gap is made clear by use of a questionnaire or survey. DeSilets further cautions that without careful consideration, questionnaires may not differentiate between *need to know*, *nice to know* and *ought to know* (italics original). Program content needs to bridge the gap, facilitating the learner in achieving the desired level of knowledge and skill performance, and behavioral proficiency. The findings of this study may impact Parish Nursing training program content by providing new insights or affirming what is already in place.

The Survey Method

Very commonly, surveys or questionnaires are a choice method of conducting a needs assessment, and they are relatively easy to construct. Bice-Stephens (2001) proposes that the place to begin designing a survey is at the end, i.e., keeping in mind how the survey will be analyzed when the responses are in. Whether one will be compiling responses by hand or electronically is driven by resources available to the researcher and the population size. Every question should be asked with an intended purpose. Items can be closed ended by having them rated on an ordinal scale, or selected from multiple choice or other forced choice answers. Conversely, using open-ended questions leaves the respondent free reign in how to answer, usually by short answer or essays of varying lengths. Although closed-ended questions are easier to tabulate, open-ended questions may uncover information the researcher did not think about. This can be accomplished by providing a space for comments under the question or at the end of the survey. The survey for this study had both forced choice answers and comment boxes following the three questions about each Parish Nursing skill.

Gupta (1999) proposes that the order of the questions should be that the simple and more interesting ones be placed in the beginning, followed by the more sensitive questions. Adding to that, this author feels that questions should be grouped into like topics, rather than randomly mixed throughout the survey to present a logical, orderly sequence to the survey. Sue and Ritter (2007) caution that the first question should be short, simple, and if possible, fun for the respondents (p. 62). This is based on the premise that respondents may suppose that the complexity of the first question is

indicative of the entire questionnaire and possibly not even take the survey if it is seemingly difficult. Sue and Ritter also suggest that the demographic items should be placed near the end of the questionnaire due to the possible sensitivity of their nature. The converse applied to this survey. The demographic items were placed at the beginning of the survey as they are simple, and closed-ended, and served as an easy introduction to the survey.

Source of the Instrument

It is unrealistic to expect that all needs will be resolved by Parish Nursing education process, so it is important to differentiate between nice-to-know and have-to-know responses. Prioritization of the perceived needs is necessary when addressing real learning needs. Brzytwa, Copeland, and Hewson (2000) compared the perceived needs of employers and nurse educators regarding specific managed care competencies, a relatively new, but extensively widespread role for nurses at that time. Their survey consisted of 19 managed care competencies based on findings from nursing and health care literature. Brzytwa, et al. used a previous survey of physicians who were also employees of managed care systems, to provide the template of the survey which was modified to be more specific to nursing. For each of the 19 competencies, nurse respondents answered three questions:

- A. How important do you feel this skill is for successfully practicing in a managed care environment?
- B. What percentage of nurses who have recently affiliated with or graduated

from your organization is deficient in this skill?

C. How important is it for schools of nursing to enhance nursing education in this competency?

Answers to questions A and C used a 1 – 5 Likert scale while question B was a percentage. The researchers calculated a “composite score” of the responses by adding A and C scores, and multiplying the sum by the B scores. The possible range of the composite scores was 0 through 10, with 10 representing the greatest combined perception of importance, deficiency, and need of educational enhancement. The findings of this study were somewhat unusual. Nurse employers rated deficiencies as higher than did the nurse educators, even though both rated the competencies with high importance. The researchers questioned whether or not they were witnessing the well-known phenomenon of reluctance to change. Since managed care competencies are not well understood or practiced by the nurse educators, they may find it easier to do ‘more of the same,’ than to initiate teaching the unfamiliar competencies (Brzytwa, et al., 2000). Since the Learning Needs of Novice Parish Nurses survey is a comparable inquiry, a similar format of questionnaire items was used to construct a ‘composite’ score for the Parish Nursing skills.

Alston and Bowles (2003) used a two pronged approach to needs assessment: needs identification and needs analysis (p. 123). The needs of the target group should not only be identified, but should also be ranked in order of priority. Alston and Bowles (2003) also see assessment as the initial step in the process of program evaluation. These authors take a different perspective of this process. They feel that needs

assessment and evaluation are tasks of the target community, and that the researcher simply facilitates the process (p. 124). Additionally, the needs assessment guides whatever change is to be effected, and is an objective way to know that the program is responding to the participants' felt needs. A needs assessment clarifies the problem, a preliminary step, before looking into the solution of the problem. Alston and Bowles (2003) caution that needs analysis is not an end in itself; but rather a means of gathering data needed to ultimately make informed program planning decisions. The results of this study provided more affirmation that the curriculum was well meeting the learning needs of novice Parish Nurses and this information needs to be considered in future curriculum revisions.

McKillip (1998) also thoroughly discusses the assessment process, ironically using very similar terminology as Alston and Bowles. For McKillip (1998), a needs analysis has two primary components: *need identification* and *need assessment* (italics are original). The need analysis is a decision-aiding tool for program planning and program development (1998, p. 261). McKillip formally lists five steps in the Need Analysis: 1) Identification of users and uses, 2) description of the target population and service environment, 3) need identification, 4) need assessment, and 5) communication. McKillip advises that the effort given to communication should equal that given the other steps (1998, p. 265). Ideally, there is a cycle of need analysis – the decision, data gathering, analysis, and integration which should repeat until further cycles are deemed unnecessary. As McKillip acknowledges, the cycle doesn't happen in reality – life is not that organized. Communication of the findings of this study to the IPNRC will be

important for future revisions of the Basic Preparation Curriculum for Parish Nursing and to share with the 130+ educational partners or the IPNRC.

Electronically Collected Assessments

Too often programs go un-assessed for many reasons, i.e., time, money, or lack of expertise (Single & Muller, 2001). Nevertheless, assessment is necessary to identify best practices for the field. According to Single and Muller, there are two modes for electronically collecting assessment data: e-mail surveys and web-based assessment instruments. E-mail servers have different formants and different page widths which can make a survey appear very different from the original sender's vantage point. The altered appearance can be very difficult for respondents to read. Web-based surveys can control these problems and can instantly keep tally as the responses come in. This is quick and almost eliminates data entry errors that are a risk when done manually. This survey, A Learning Needs Assessment of Parish Nurses, utilized the web-based survey option utilizing Flashlight Online. With Flashlight Online, frequency tallies are continuously updated and all the data is easily exported to an Excel spreadsheet for analysis.

O'Mara, Bauer-Wu, Berry, and Lillington (2007) conducted a web-based needs assessment utilizing ZoomerangTM (Market Tools, Inc., Mill Valley, CA), a software program that facilitates designing electronic surveys and analyzing results. The survey was sent by e-mail to 3,530 of potential respondents across the United States. The researchers wanted to determine the familiarity of the respondents with cancer

cooperative groups (CCGs) that are used for cancer research, and the advantages and barriers felt by the respondents regarding doing research with CCGs. This descriptive study might have been prohibitive due to cost if it had not been web-based, or the sample might have had to be much smaller. The Learning Needs Assessment of Parish Nurses was conducted at a very low cost since Flashlight Online was available to the researcher without cost. Paper copies were offered, but none were requested. Outside of the time needed to construct and prepare the survey, the only real expense involved was the respondent's time, which was less than a half an hour.

Shadel et al. (2004) conducted a mailed survey to 3,074 local public health departments in November, 2001, which followed the terrorist attack of September 11, 2001. The researchers had a unique advantage in that a similar survey had been conducted in October of 2000, providing authentic pre/post data collection conditions. The 2000 survey had 35 questions, but the 2001 survey was shortened to 26 questions, so it could be reasonably completed in 15 minutes. Answers were scored on a 5 point Likert scale and returned anonymously. Due to the anonymity, pre/post respondents could not be matched, so the researchers utilized the bootstrap technique. This unfamiliar term is defined as follows:

In statistics, bootstrapping is a modern, computer-intensive, general purpose approach to statistical inference falling within a broader class of re-sampling methods. Bootstrapping is the practice of estimating properties of an estimator (such as its variance) by measuring those properties when sampling

from an approximating distribution. One standard choice for an approximating distribution is the empirical distribution of the observed data.

It may also be used for constructing hypothesis tests. It is often used as an alternative to inference based on parametric assumptions when those assumptions are in doubt, or where parametric inference is impossible or requires very complicated formulas for the calculation of standard errors.

The advantage of bootstrapping over analytical method is its great simplicity - it is straightforward to apply the bootstrap to derive estimates of standard errors and confidence intervals for complex estimators of complex parameters of the distribution, such as percentile points, proportions, odds ratio, and correlation coefficients. (Retrieved October 13, 2007, from [http://en.wikipedia.org/wiki/Bootstrapping_\(statistics\)](http://en.wikipedia.org/wiki/Bootstrapping_(statistics))).

Interestingly, Shadel et al. (2004) found a dramatic increase in the perceived risk of a bioterrorism attack in the United States within the next five years, but few respondents felt it (terrorism) would occur in their local community, except for those residing in the Northeast.

This study, A Learning Needs Assessment of Parish Nurses, is in a position of re-sampling following an event. This survey commenced on August 1, 2008 for six weeks. One year later, on August 1, 2009, the IPNRC released the 2009 revision of the Basic

Preparation Curriculum for Parish Nursing at the Parish Nurse Educator's Event in St. Louis, MO.

Trending in Needs Assessments

If needs assessments are taken on a regular basis, then comparisons can be made between like groups over several years time. Collins (2002) who is a Director of Continuing Education takes an annual assessment of a convenience sample of 100 nurses in order to effectively plan nursing continuing education activities. Respondents may select as many of the topic choices as they wish, but are instructed to circle only the areas of high interest which they would make an effort to attend if offered. This is another method of fine-tuning the choices to prioritize the 'really would like to know' from the 'nice-to-know.' Although Collins kept simple frequency tables to compare five year differences (1994 – 1998), a major change was found in the desire for more in the mental health category. In 1994 there were only 20 requests for "women and stress." In 1998 there were 150 requests in that category, which included topics such stress management, and bipolar disorders. Collins felt the shifts may be aligned with the changes in the current health care environment and the fears and anxieties associated with those changes. The survey for this study is built on six-point Likert scale responses to the same three questions regarding 11 prioritized Parish Nursing skills. This format facilitates and simplifies comparisons with like data from future surveys as mentioned in the previous section.

Instrument Development

Certain characteristics of a survey can impact the rate of return. Being respondent-friendly is very important, but other criteria are also essential. Ross, McDonald, and McGuinness (1996) constructed an instrument to assess nurses' knowledge of palliative care, the nursing care given when a cure is not likely at the end of life. The construction of the study was directed by the Canadian Standards of Educational Evaluation and Utilization Focused Procedures. These standards emphasize: 1) utility or useful information, 2) feasibility or practical to administer and interpret, 3) propriety or time efficient, and 4) accuracy or sound measures and technically adequate. A brief and easily administered tool was considered to be the most useful, so 86 initial dimensions of knowledge were reduced to a 25 item, true and false tool. Ross et al. (1996) admit that true/false items may be less sensitive to instruction, but they are without question, quick to answer and easy to score. Ross et al. (1996) added one more dimension to the true/false answer, a 'don't know' category in order to differentiate between lack of information and misinformation, as well as reducing guessed responses. Ross et al. wanted to also avoid ceiling effects, which is a very important consideration when the instrument would be used pre and post intervention (an educational program). A ceiling effect exists when an intervention is expected to increase knowledge, but pre test scores are at or near the top of the range for the dependent variable. The article did not disclose how the researchers controlled for the ceiling effect in their instrument. In considering whether or not to include a 'don't know' option to the survey, this author opted not to do so that the data would be dichotomous. For this same reason, a six point Likert scale was used, rather than a five point scale. This is so

that when a respondent is uncertain, they may opt for the 'middle of the road' or a neutral position, but still have to make the judgment of being slightly positive or slightly negative. Respondents for the Learning Needs of Parish Nurses wishing to be as 'neutral' as possible could enter their best 'guess' or opt to leave the question unanswered. Either way, their survey was still useable. The one question that had the highest number of skipped responses was, "What percentage of novice Parish Nurses do you feel are deficient in the skill of _____?" The respondent would have to make a subjective judgment about the deficiency level of peers or fellow colleagues about whom they might not have felt inadequate to do so. Nevertheless, adequate data was obtained for all eleven Parish Nursing skills.

Chapter 3 Method

The data collection for this assessment was a web-base questionnaire distributed to those nurses on the mailing lists of the Parish Nurse Coordinators from the Indiana Center for Parish Nursing. Paper copies of the questionnaire were offered but distribution was done only by e-mail. The results were calculated by hand and electronically utilizing the Statistical Package for the Social Sciences (SPSS), Windows version 16.0. The study had the approval of the Institutional Review Board for Human Subjects from Ball State University. The author holds a Certificate of Human Participant Protections Education for Research (See Appendix F).

Population

The population for this study is based on the estimated 506 nurses who are on the e-mailing rosters of Parish Nurse Coordinators associated with the Indiana Center for Parish Nursing. The author communicated with Kelly Peisker, President of the Indiana Center for Parish Nursing, for permission to use the Center's mailing list (See Appendix A). Ms. Peisker and the Parish Nursing Board responded that it would be best that the Indiana Center for Parish Nursing distribute the Letters of Invitation to approximately 506 Parish Nurses and declined the author's offer to come to the Center to do this for them.

There were two requirements to be a respondent for the survey; the person had to be a Registered Nurse (RN) and also had to have completed the Basic Preparation Curriculum for Parish Nursing from the International Parish Nurse Resource Center in

St. Louis, MO, or similar training. As a gatekeeper to dissuade unqualified recipients of the Letter of Invitation (Appendix B) from proceeding, the survey started out with discerning demographic questions that verified RN status and Parish Nursing training. For example, the first survey statement asks, “The year I completed a basic Parish Nursing course is _____” and “The highest health care related degree I have completed is ...” This tactic was effective as none of the surveys were deemed unusable.

The Response Rate

It is estimated that approximately 506 Parish Nurses received the Letter of Invitation (Appendix B) from the Indiana Center for Parish Nursing via their local Parish Nurse Coordinator. As of September 22, 2008, the online survey had 32 respondents which became the sample of Parish Nurses for this study. Based on the 32 responses obtained, the return rate for the survey was 6.32 %.

It is difficult at the present time to secure a valid list of Parish Nurse affiliates of the Indiana Center for Parish Nursing. The Center has a group of Parish Nurse Coordinators who meet with some regularity to make plans and decisions. These individual Coordinators handle their own mailing, which is primarily e-mailing. The author tried several times to obtain assurance that the Letter of Invitation was in fact distributed by the Parish Nurse coordinators, but could not get a clear answer. The author requested that each Coordinator be asked for a count of how many persons are on their distribution list. It was thought that 506 received the e-mail, but this was not confirmed to the author’s knowledge.

The low response rate (6.32%) was naturally disappointing especially since it does not seem to be typical of Parish Nurses. A hallmark study by Solari-Twadell (2002) had a response rate of 54% ($n = 1161$) which is especially notable since the Solari-Twadell research tool was forty-one pages long! Another study by McGinnis and Zoske (2008) was believed to have a response rate of 29% but the authors cautioned that an accurate response rate for them was almost impossible since some survey recipients might not have been 'active Faith Community Nurses.'

Timeframe of the Survey

The window of time that this study addresses is the year when the novice Parish Nurse is initiating the Parish Nurse ministry, following the completion of a basic Parish Nursing training course. During this crucial time, when a ministry is being initiated, foundational questions and dilemmas are inevitable and this, of course, is when the Parish Nurse is learning the new role. This study provides verification of those skills that Parish Nurses of various levels of expertise perceived to be needed to successfully initiate a Parish Nurse ministry. Utilizing the *accountability process* from Vella et al., (1998) this study examined what learning needs are perceived to be needed by novice Parish Nurses during the *transfer* of or the actual application of their learning from the Basic Parish Nursing Preparation course. All respondents, new and experienced, were asked to frame their responses to the time during which the novice Parish Nurse is setting up a ministry.

Data Collection

Respondents were asked in the Letter of Invitation distributed by e-mail, to click on the URL to obtain direct access to the online survey, The Learning Needs Assessment of Parish Nurses. Two weeks following the initial Letter of Invitation, a Reminder Letter (Appendix B) was sent to Ms. Peisker via e-mail attachment for distribution to the same Parish Nurse Coordinators from the Indiana Center for Parish Nursing.

As surveys were submitted, frequencies for each question were automatically tabulated by Flashlight Online. The data from Flashlight Online was exported to an Excel spreadsheet for analysis.

Survey Procedure

The electronic format for the survey utilized Flashlight Online and all questions were all custom-written by the author following the content validity surveys. Access to the link for the survey was provided in the Letter of Invitation (see Appendix B) and Reminder Letter (Appendix B) which were distributed by e-mail. The Reminder Letter was identical to the Letter of Invitation except for the beginning which read:

Just a quick reminder to have you complete my dissertation survey about the learning needs of novice Parish Nurses. If you have already completed this survey, I thank you and please disregard this notice.

The survey focuses on the learning needs of novice Parish Nurses during the time...

When respondents clicked on the link, it opened directly to the survey with no other steps in between. Survey respondents did not need a user name or password to access the survey, so each response was unidentifiable.

Timeline

The timeline of events for this study was as follows:

- July 15, 2008 Approval was obtained from IRB at Ball State University.
- August 1, 2008, the Survey was accessible from Flashlight Online which coincided with the e-mail distribution of the Letter of Invitation by the Indiana Center for Parish Nursing.
- August 14, 2008, the Indiana Center for Parish Nursing was asked to distribute the Reminder Letter by e-mail.
- September 22, 2008, the last response for this study was submitted.

Letter of Invitation

The Letter of Invitation (see Appendix B) was an e-mail message which introduced the investigator, described the purpose of the survey, and assured confidentiality and anonymity of the responses. It stated that the respondent acknowledges Informed Consent by accessing and submitting the survey, and that the participant could withdraw from the study at any time without penalty. The letter directed the respondent to begin the survey by clicking on the live uniform resource locator (URL) given in the letter. Finally contact information is provided in the letter.

Questions and comments can be directed to the investigator or the Chair of the Dissertation Committee by e-mail or by phone.

The Survey

The survey began with six completion statements for demographic information, followed by the eleven novice Parish Nurse skills, each having three questions and an open text box. Having the demographics at the beginning served an additional purpose of 'gate keeping' to dissuade any non-nurses from continuing to complete the survey. If a respondent could not state when she/he completed the basic Parish Nurse training course, they would realize that this survey is not intended for them.

Origin of the Skills in the Survey

The novice Parish Nurse skills used for the survey were based on the Getting Started module from the Basic Preparation Curriculum for Parish Nursing. In all there are twenty Parish Nursing skills mentioned in this module, but the number was reduced in order to keep the survey brief, yet be enough to gather informative data. The complete list of the original twenty skills is given in the Content Validity Experts' Survey 1 (See Appendix C).

The reduction process was accomplished by two rounds of content validity surveys from Parish Nursing experts. The first survey of the experts reduced the list of Parish Nursing skills from 20 to 15. The second survey of the experts further reduced the list of skills to 11, which include:

- Functioning in the organizational structure of the church. This includes the line of responsibility, reporting and independence
- Making an assessment of the church's health needs
- Educating the congregation in understanding the role of the Parish Nurse
- Making out the Parish Nursing budget
- Maintaining a documentation system
- Maintaining confidentiality of everyone with whom the Parish Nurse works
- Providing health activities for the congregation
- Praying with others
- Working with volunteers
- Utilizing local, regional, national, and denominational resources for the Parish Nurse
- Providing spiritual care for members of the congregation

For any skill not in the final list of eleven, respondents were invited to submit their comments in the open text comment box at the end of the survey.

Use of the Six Point Likert Scale

A six point Likert scale was used because it dichotomizes the options and leaves no neutral central point as would be possible on a five point Likert scale. Instead, in instances where the respondent did not feel strongly positive or negative, one of the center two options could be selected. This way the respondent could remain as 'neutral'

as possible, but would still have to decide if they felt very slightly positive as in the third option from the top of the choices, or very slightly negative as in the fourth option from the top of the list of choices. In essence, respondents were forced to take a positive or negative stand, even if they chose to be as close to neutral as possible.

Content Validity

Content validity is a means to determine that the questions *are* asking what they *are supposed to be* asking, or that they are content valid. Fowler (1998) writes that, “no matter how big and representative the sample, no matter how much money is spent on data collection and what the response rate is, the quality of the resulting data from a survey will be no better than the questions that are asked” (p. 371). The clarity of the questions on an electronic survey is essential since the researcher is not in close proximity or readily accessible for clarification when respondents are taking the survey.

According to Polit, Beck, and Owen (2007) nursing researchers typically demonstrate content validity by using the content validity index (CVI), based on ratings of item relevance from experts in the field. The content validity for the items in this survey, The Learning Needs Assessment of Parish Nurses, was based on the ratings of four experts who were colleagues of the investigator. Three of the experts were doctoral-prepared nurses: RS has been teaching Parish Nursing for almost ten years, LW has taken the Basic Preparation Curriculum for Parish Nursing and has been an active Parish Nurse for more than five years, and SH is an RN with expertise in teaching nursing research, statistics, and evaluation. A fourth colleague, MB, is Masters prepared, has

been an educational partner of the IPNRC for five years, and has been an advisor to more than 50 novice Parish Nurses. The number of four experts was based on the available resources of the investigator for time and ready access to persons with the appropriate expertise. Polit, Beck, and Owen (2007) and Lynn (1986) propose that three experts would be the minimum acceptable number for a content validation effort.

The content validity survey for the experts used a four point scale to rate the items. Polit, Beck, and Owen (2007) point out that an even numbered scale makes it is possible to dichotomize an ordinal scale into *relevant* and *not relevant* items. Following this concept, the labels of 1 = *not relevant*, 2 = *somewhat relevant*, 3 = *quite relevant*, and 4 = *highly relevant*, the item CVI would be computed as the number of experts giving a rating of either 3 or 4, divided by the number of experts – the proportion in agreement. For example, an item that was rated as *quite* or *highly* relevant by four out of five judges would have an item CVI of 0.80 [*italics original*] (Polit and Beck, 2006, p. 491).

The content validation process was carried out by sending a Flashlight Online survey of twenty Parish Nurse skills drawn up by the investigator and based on the Getting Started module from the Basic Preparation Curriculum for Parish Nursing. Each of the content experts received an e-mail message asking them to anonymously rate the relevance of each skill for a novice Parish Nurse in setting up a Parish Nursing ministry (See Appendix C for a copy of the cover letter 1, and for Survey 1 sent to the content experts). The CVI values were computed for each item with the responses based on values of one to four. For the first round of CVI value ratings, items with scores greater

than 3.0 were retained, and those with scores less than 3.0 were discarded. The first cut reduced the number of items from 20 to 15 (see Content Validity Results 1, Appendix C). The remaining items were then resubmitted to the panel of experts for a second judgment (see Appendix C for a copy of the Cover Letter 2, and for Survey 2). For the second cut, three of the four content experts responded and the CVI values were computed in the same manner as for the first round. Eleven items had a value of 3.0 or more and these were the Parish Nursing skills used for the survey (See Content Validity Results 2 in Appendix C).

Survey Copy

A copy of the survey, entitled A Learning Needs Assessment of Parish Nurses is provided (see Appendix D). This is a print version of the survey as it was on Flashlight Online and as it was approved by the Institutional Review Board of Ball State University. Respondents accessed the survey by clicking on the live link given in the Letter of Invitation or Reminder Letter.

Data Collection and Storage

Data for this study was collected and stored by Flashlight Online and is author/investigator password protected at the Flashlight Web site. The data available to the author were the frequencies of the various responses and the typed content of text from the open text boxes on the survey. The data are completely anonymous to the author/investigator and to Flashlight Online (See Appendix E).

The frequency data was exported in an aggregate format to Excel for analysis. At no point where the data is held by Flashlight Online or by the investigator/author, does it contain any identifiers to any of the respondents (See Appendix E). The data held at Flashlight Online is archived and can be accessed by the survey author only by user name and password. Flashlight Online stores the data indefinitely (See Appendix E).

Data Analysis

A six point Likert scale was used for the answers to the skill questions on the survey. The first question asked about the perceived importance of the skill for successfully beginning a Parish Nurse ministry. The answer scale options included:

- Of utmost importance (1)
- Highly important (2)
- Moderately important (3)
- Somewhat important (4)
- Less Important (5)
- Not important (6)

The second question for each skill asked what percentage of novice Parish Nurses the respondent perceived as deficient in the respective skill. The six point Likert scale included:

- Less than 50% (1)
- 50 – 59% (2)
- 60 – 69% (3)

- 70 – 79% (4)
- 80 – 89%(5)
- 90 – 100% (6)

The third question for each skill asked how important it was for the Parish Nursing course to add further training on the respective skill. The six point Likert scale includes:

- Of utmost importance (1)
- Highly important (2)
- Moderately important (3)
- Somewhat important (4)
- Less Important (5)
- Not important (6)

The survey results gave the frequency of respondents who chose each response option. The raw response data was downloaded into an Excel spreadsheet and edited to facilitate readability and reduce errors. It was then downloaded into Statistical Package for the Social Sciences (SPSS) for analysis.

The Composite Score

Each survey item had a Composite score computed, which was figured by adding the perception of importance scale number, the deficiency scale number and the need to add more education scale number. The best case scenario would be $1 + 1 + 1 = 3$, the

lowest concern or most desirability for a particular Parish Nurse skill. The worst case scenario would be $6 + 6 + 6 = 18$.

Composite scores for the eleven skills were computed manually and then rank ordered to determine which was perceived as priority. This analysis satisfied the question of which Parish Nursing skills were perceived as important and in need of more emphasis in the Parish Nursing training courses, and which skills novice Parish Nurses are perceived to be most deficient.

Descriptive Statistics

This study utilized descriptive statistics to examine each item to generate a prioritized summary of the skills needed to set-up a Parish Nurse ministry. The data was collected using a six point Likert type ordinal scale for all responses and thus the importance of Parish nursing skills, the greatest lack of knowledge about the skill in novice Parish Nurses, and the greatest need for further education were ranked. The rank order of the means was used to obtain fine differences between the skills. The mean was computed for each Parish Nursing skill utilizing SPSS for Windows, version 16.0.

Chapter 4 Results

Descriptive statistics were calculated for the responses to the survey, “A Learning Needs Assessment of Parish Nurses” and each category of demographic data ($N = 32$). Data were analyzed manually in some instances, and in others the Statistical Package for the Social Sciences (SPSS) version 16.0 for Windows was used, such as for the stacked bar graph.

Demographics

Demographic information requested on the survey included: 1) year the nurse completed a basic Parish Nursing course, 2) religious denomination, 3) age range, 4) highest health care related degree completed, 5) years the nurse had served as an active Parish Nurse, and 6) the respondents self reported rank on Benner’s scale from Novice to Expert. The number of respondents to the survey totaled 32 ($n = 32$) and there was no missing responses for the demographic data.

The year that the nurse completed the Parish Nursing class was evenly distributed between the years of 1996 to 2008, except for 2002 in which there were 7 or 21.9% of the respondents (see Table 4.1). The author does not have an explanation of why 2002 had a high frequency. It is also noted that there were no participants from the year 1999 or 2004 with no known explanation for this.

Table 4.1

<i>Parish Nurse Class Year</i>					
Class	Year	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1996	2	6.2	6.2	6.2
	1997	2	6.2	6.2	12.5
	1998	1	3.1	3.1	15.6
	2000	2	6.2	6.2	21.9
	2001	3	9.4	9.4	31.2
	2002	7	21.9	21.9	53.1
	2003	3	9.4	9.4	62.5
	2005	4	12.5	12.5	75.0
	2006	2	6.2	6.2	81.2
	2007	2	6.2	6.2	87.5
	2008	4	12.5	12.5	100.0
Total		32	100.0	100.0	

Ten different religions were represented with Catholic being the most frequent (14 or 43.8%) and United Methodist second (5 or 15.6%); all other religions were at less than 10% (see Table 4.2). It is possible that the Catholic influence may be related to the fact that St. Vincent Hospital, a Catholic hospital in Indianapolis, has underwritten many of their employee expenses in taking the Parish Nursing course. St. Vincent Hospital has

also paid for many other nurses to take the Parish Nursing course, with no religious requirement, and no stipulation on hospital affiliation. In addition, the nurses probably took their Parish Nurse training at the University of Indianapolis, a Methodist based School of Nursing, because it was the only site offering the course within a 60 mile radius of the city. University of Indianapolis did require a commitment from nurses sponsored by the Methodist Church and the pastor of the Parish Nurse's church also had to agree with the commitment to establish a Parish Nurse ministry in the church. This may explain why the religion of second highest frequency was Methodist.

Table 4.2

Religions of the Parish Nurses

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Baptist	3	9.4	9.4	9.4
Lutheran	2	6.2	6.2	15.6
Catholic	14	43.8	43.8	59.4
Christian	3	9.4	9.4	68.8
Church of the Brethren	1	3.1	3.1	71.9
Disciples of Christ	1	3.1	3.1	75.0
Free Methodist	1	3.1	3.1	78.1
Pentecostal	1	3.1	3.1	81.2
Transdenominational	1	3.1	3.1	84.4
United Methodist	5	15.6	15.6	100.0
Total	32	100.0	100.0	

The age of the Parish Nurse respondent was most frequently reported in the 56 – 65 range (12 or 37.5 %); second most frequently was the 46 – 55 range (9 or 28.1 %) and none of the respondents were 25 years or less (see Table 4.3).

Table 4.3

Age Range of Parish Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	26 - 35	1	3.1	3.1	3.1
	36 - 45	5	15.6	15.6	18.8
	46 - 55	9	28.1	28.1	46.9
	56 - 65	12	37.5	37.5	84.4
	more than 65	5	15.6	15.6	100.0
	Total	32	100.0	100.0	

The most frequently Health Care related degree completed was reported as Baccalaureate (12 or 37.5%), then Masters (9 or 28.1 %); Associates (5 or 15.6 %); Diploma (4 or 12.5 %) and Doctorate (2 or 6.2%) as shown in Table 4.4.

Table 4.4

Highest Health Care Related Degree Completed by the Parish Nurse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Associates	5	15.6	15.6	15.6
	Diploma	4	12.5	12.5	28.1
	Baccalaureate	12	37.5	37.5	65.6
	Masters	9	28.1	28.1	93.8
	Doctorate	2	6.2	6.2	100.0
	Total	32	100.0	100.0	

The number of years that the nurse has served as a Parish Nurse ranged from 'less than a year' to thirteen years. Most of the respondents had been a Parish Nurse for five years (7 or 21.9%), or less than a year (6 or 18.8 %); see Table 4.5. The number of respondents for all the other number of years was three or less with no respondents reporting four years, nine years or ten years.

Table 4.5

Number of Years as a Parish Nurse

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than a year	6	18.8	18.8	18.8
	1 year	3	9.4	9.4	28.1
	2 years	2	6.2	6.2	34.4
	3 years	1	3.1	3.1	37.5
	5 years	7	21.9	21.9	59.4
	6 years	2	6.2	6.2	65.6
	7 years	4	12.5	12.5	78.1
	8 years	2	6.2	6.2	84.4
	11 years	2	6.2	6.2	90.6
	12 years	2	6.2	6.2	96.9
	13 years	1	3.1	3.1	100.0
	Total	32	100.0	100.0	

Respondents were asked self-rank themselves on Benner's (1984) ranking of skill levels from novice to expert. All five levels of expertise were represented in the survey respondents with the most frequently reported level being Competent (12 or 37.5%) and then Novice (8 or 25%); see Table 4.6.

Table 4.6

Benner's Rank of the Parish Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Expert	2	6.2	6.2	6.2
	Proficient	7	21.9	21.9	28.1
	Competent	12	37.5	37.5	65.6
	Advanced Beginner	3	9.4	9.4	75.0
	Novice	8	25.0	25.0	100.0
	Total	32	100.0	100.0	

Only two (6.2%) Parish Nurses felt that they were at the expert skill level as Parish Nurses, and both of these nurses have served as an active Parish Nurse for more than ten years (See Figure 4.1.)

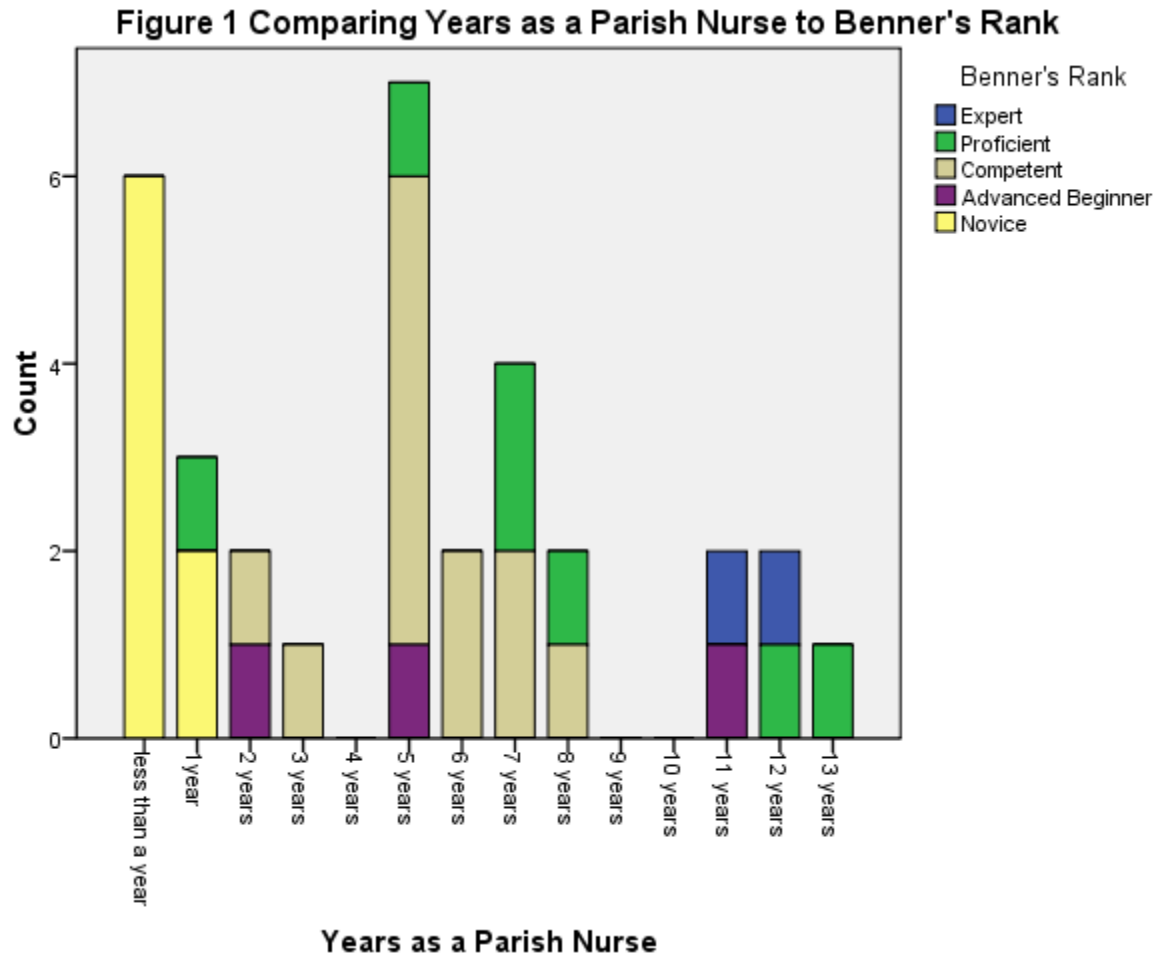


Figure 4.1. Comparison of Years as a Parish Nurse and how the Parish Nurses ranked themselves on Benner's scale of skill levels ($n = 32$).

Those Parish Nurses with less than a year of experience consistently ranked themselves at the 'Novice' level. The second lowest ranking, 'Advanced Beginner' was reported for Parish Nurses with two years, five years, and 11 years of experience. The rank of 'Proficient', which is second to the highest ranking, was reported across the continuum from one year to 13 years, the highest number of years reported as an active Parish Nurse. The two expert level nurses each had 11 years or 12 years as active Parish Nurses. The nurse with the most number of years (13) ranked herself as Proficient. One

of the nurses with 11 years of active Parish Nursing ranked herself as Advanced Beginner. The rationale for the nurses choice in self-ranking was not requested, but a possible explanation may be that this nurse of 11 years experience does her ministry in a very part-time manner, such as one or two days a month, and so does not feel that she gained Parish Nursing skills to a higher level.

In studying Figure 4.1 it appears that nurses with 5 years or more of experience easily ranked their skill level at 'Proficient', the level preceding the 'expert' level. The graph shows one exception. A Parish Nurse with one year experience ranked her skill level also at Proficient. A possible explanation may be that the nurse was doing many Parish Nursing skills prior to taking formal Parish Nurse training, so this level of skill is possible at a point one year following the Parish Nurse course.

Research Question # 1

The first Research Question for this study was: *What skills do Parish Nurses perceive as important in starting up a Parish Nurse ministry?* Respondents were asked to rank the importance of each of the 11 Parish Nursing skills from 'Of Utmost Importance' to 'Not Important' on a six point Likert scale. When looking at the rank order of the means of the responses for the importance of each Parish Nursing skill in ascending order, a mean nearest to one would show almost complete agreement that the skill would be *Of utmost importance*. As the value of the mean increases numerically, the value of importance of the Parish Nursing skill would be decreasing. This is based on the

premise that each of the possible responses on the Likert scale was given a numeric value to correlate with the label. For example:

- 1 corresponds to 'Of utmost importance'
- 2 corresponds to 'Highly important'
- 3 corresponds to 'Moderately important'
- 4 corresponds to 'Somewhat important'
- 5 corresponds to 'Less Important'
- 6 corresponds to 'Not important'

The importance of 'Keeping Confidentiality' ranked the highest, having the lowest group mean of 1.09 (see Table 4.7). This is followed by the importance of 'Praying' with a mean of 1.56. On the bottom end of the spectrum, the skill with the highest mean would be ranked the lowest in importance on the list of 11 Parish Nursing skills. This position fell to the importance of 'Making a Budget' (3.22) which gives it an approximated rank of '*moderately important*'.

Table 4.7

Means of Importance of the Parish Nurse Skill in Ascending Order

Parish Nurse Skill	N	Mean
Importance of Keeping Confidentiality	32	1.09
Importance of Praying	32	1.56
Importance of Working w/Volunteers	32	1.66
Importance of Educ. about Role as PN	32	1.84
Importance of Spiritual Caregiving	32	1.88
Importance of a Documentation System	32	2.12
Importance of Health Activities	31	2.16
Importance of Utilizing Resources	32	2.19
Importance of Making an Assessment	32	2.22
Importance of Functioning in an Org.	32	2.59
Importance of Making a Budget	32	3.22
Valid N (listwise)	31	

Another analysis of the data would be to examine the frequencies of respondents who ranked the Parish Nurse skill in the highest third of the options, or the rank of 'Of Utmost Importance' or the rank of 'Highly Important'. Table 4.8 illustrated this analysis utilizing of the sum of the highest two ranks versus the remaining four

lower ranks on the six point Likert scale. The higher the sum of the top one third of the response options, the greater reinforcement of the hierarchy of the Parish Nursing skills; see Table 4.8.

Table 4.8

Sum of Frequencies of the Importance of the Parish Nurse Skills Ranked as 'Utmost' or 'Highly Important'

Parish Nurse Skill	N	Frequency	Percent	Sum of the Percents ranked as Utmost and Highly Important
Importance of Keeping Confidentiality				
Of Utmost Importance	32	29	90.6	100.0
Highly Important		3	9.4	
Other		0	0	
Importance of Praying				
Of Utmost Importance	32	18	56.2	90.6
Highly Important		11	34.4	
Other		3	9.3	
Importance of Working with Volunteers	32	20	62.5	75.0
Of Utmost Importance		4	12.5	
Highly Important		8	25	
Other				
Importance of Spiritual Caregiving				
Of Utmost Importance	32	15	46.9	75.0
Highly Important		9	28.1	
Other		8	25.0	
Importance of Health Activities				
Of Utmost Importance	31	7	22.6	74.2
Highly Important		16	51.6	
Other		8	25.8	
Importance of Making an Assessment				
Of Utmost Importance	32	7	21.9	65.7
Highly Important		14	43.8	
Other		11	34.4	

Importance of a Documentation System	32	11	34.4	65.6
Of Utmost Importance		10	31.2	
Highly Important		11	34.2	
Other				
Importance of Utilizing Resources	32	9	28.1	59.3
Of Utmost Importance		10	31.2	
Highly Important		13	40.6	
Other				
Importance of Functioning in an Organization	32	2	6.2	46.8
Of Utmost Importance		13	40.6	
Highly Important		16	53.1	
Other				
Importance of Making a Budget	32	1	3.1	34.3
Of Utmost Importance		10	31.2	
Highly Important		21	65.6	
Other				

Note. Responses are grouped for the 1st rank (Utmost), 2nd (Highly) Important and Others which includes 3rd (Moderately), 4th (Somewhat), 5th (Less), and 6th (Not) Important

Well over 50% of the respondents ranked nine of the eleven skills as either 'Of Utmost Importance' or 'Highly Important'. The two exceptions were the 'Importance of Functioning in an Organization' (46.8%) and 'Making a Budget' (34.3%). There was very little change in the rank order when the frequencies for the Parish Nurse skills (Table 4.8) were compared to the rank order of the means (Table 4.7). However, the skills of Keeping Confidentiality (100%) and Praying (90.6%) maintained the highest frequencies, consistent with the rank order of the means, 1.09 and 1.56 respectively from Table 4.7. Only one Parish Nurse skill was ranked as *Not Important* by one respondent, and that was the 'Importance of Making a Budget'. Some of the comments from the Parish Nurses make it clear that when no money is allocated for the ministry, making out a

budget is a low priority: “The budget is simple, most churches have little funds to work with, so you do without or get it donated”, and “[we] learn to make do with little as the poor do and be okay with it.”

The Composite Score

A composite score (Table 4.9) was calculated by summing the *means* of the three factors or questions for each Parish Nursing skill, i.e., the importance of the skill, the percentage of novices that are perceived to be deficient in the skill, and the need to add more education concerning the skill. The possible range for this three factored composite score would be from 3 (the perfect ideal) to 18 (worst case scenario). For example, the composite score of the Parish Nurse Skill of ‘Keeping Confidentiality’ was obtained by adding the mean of the importance of the skill (1.09), the mean of the percentage of perceived deficiency in novice Parish Nurses (1.50) and the mean of the need for more education for the skill (2.72) which totals to 5.31, the composite score for that skill. Of the 11 Parish Nurse skills, the composite score for ‘Keeping Confidentiality’ (5.31) and ‘Praying’ (6.09) again ranked the highest. The skills of ‘Functioning within an Organization’ (7.63) and ‘Making a Budget’ (8.98), ranked the lowest.

Table 4.9

Composite Score of the Parish Nurse Skills in Ascending Order

Parish Nurse Skill	Mean of the Importance of the Skill	Mean of the Percentage of Deficiency in Novice Parish Nurses	Mean of the Need for More Education for the Skill	Composite Score for Each Skill
Keeping Confidentiality	1.09	1.50	2.72	5.31
Praying	1.56	2.37	2.16	6.09
Spiritual Caregiving	1.88	2.31	2.25	6.44
Working with Volunteers	1.68	2.21	2.69	6.58
Health Activities	2.16	1.82	2.72	6.7
Making an Assessment	2.22	2.07	2.45	6.74
Educating about the Role of the Parish Nurse	1.84	2.56	2.34	6.74
Maintaining a Documentation System	2.12	2.27	2.41	6.8
Utilizing Resources	2.19	2.54	2.50	7.23
Functioning within an Organization	2.59	2.75	2.29	7.63
Making a Budget	3.22	2.57	3.17	8.98

Note. Composite Score computed by adding the means of each of the three factors of The Parish Nurse Skill.

Interpretation 1

These findings support the validity that the eleven selected Parish Nursing skills are perceived to be important in starting up a Parish Nurse ministry. The skill of 'Keeping Confidentiality' ranks the highest and many of the comments from the respondents centered on the fact that it is "vital to the success of Parish Nursing" and "most all nurses understand this".

The remaining ten Parish Nursing skills ranked between six and nine (6.09 to 8.98) for the skill composite score. This is significant in that the half way point of the composite score would be 10.5 and the composite scores for all of the Parish Nurse skills in the study were well below this point or perceived positively by the respondents.

The value of 10.5 being the half way point was figured in this manner. The lowest possible score on the six point Likert scale is one and the highest is six, so the difference between one and six is five. Dividing five in half equals two and a half. Taking the lowest unit (one) and adding two and a half puts the center of the Likert scale at three and a half. Using the figure of three and a half for each of the factors in the composite score, the mid value would be $3.5 + 3.5 + 3.5 = 10.5$. A figure lower than this point for a composite score would be favorable, and numbers above 10.5 would be increasingly less favorable

There was an additional opportunity for any respondent to comment about any other skill that would be important. No other skills were suggested. Considering all four areas of consideration for Research Question # 1, it is reasonable to state that this

sample of Parish Nurses perceives these eleven Parish Nursing skills to be important in starting up a Parish Nurse ministry.

Research Question # 2

The second Research Question for this study was: *Which skills do Parish Nurses perceive as most deficient in novice Parish Nurses who have completed a Parish Nursing Preparation course?* Respondents were asked to rank what percentage of novice Parish Nurses they perceived to be deficient in each of the 11 Parish Nursing Skills. A six point Likert scale ranging at the highest (most desirable) rank of 'Less than 50 %' to the lowest rank (least desirable) of '90 – 100 %' was used. As discussed with Research Question 1, a six point Likert scale has the advantage of forcing a respondent's choice to be either slightly positive as in the third option from the top of the choices, or slightly negative as in the fourth option from the top of the list, if a neutral stance was intended.

As with the Likert scale for the degree of importance, this scale assigns a numeric value to the percentage of deficiency in novice Parish Nurses response label. For example:

- 1 corresponds with 'Less than 50%'
- 2 corresponds with '50 – 59%'
- 3 corresponds with '60 – 69%'
- 4 corresponds with '70 – 79%'
- 5 corresponds with '80 – 89%'
- 6 corresponds with '90 – 100%'

When looking at the rank order of the means of the responses for the percentage of novice Parish Nurses perceived to be deficient in a skill in ascending order, a mean nearest to one would the deficiency of the Parish Nursing skill is perceived to be less than 50 percent. As the value of the mean increases numerically, the percentage of novice Parish Nurses perceived to be deficient in the skill would be increasing i.e., an increasingly less desirable situation.

This survey question asked for a subjective judgment on the part of the respondent. In essence, respondents were to rank the deficiency level of peers or fellow colleagues, a judgment that the respondent might feel knowledgeable enough to make. This reservation in making such a judgment may be the reason that this question had missing data on every survey for the 11 Parish Nursing skills.

As seen in Table 4.10, the skills of Keeping Confidentiality (1.50) and Health Activities for the Congregation (1.82) have means below two and therefore rank highest. All other deficiency ratings for the remaining Parish Nursing skills had means between a very narrow range of 2.07 to 2.75. Means closest to two would indicate that respondents felt that 50 to 59% of the novice Parish Nurses was deficient in the skills. The skills of 'Making a Budget' and 'Functioning in an Organization' had the two lowest means, 2.57 and 2.75 respectively. These means are closer to 3, suggesting that nearly 60–69% of novice Parish Nurses was perceived to be deficient in these two skills.

Table 4.10

Means of the Frequency of Deficiency in Novice Parish Nurses – Given in Ascending Order

Parish Nurse Skill	N	Mean
Novice Deficient in Keeping Confidentiality	30	1.50
Novice Deficient in Health Activities	28	1.82
Novice Deficient in Making an Assessment	28	2.07
Novice Deficient in Working w/Volunteers	29	2.21
Novice Deficient in Documentation Sys	30	2.27
Novice Deficient in Spiritual Caregiving	29	2.31
Novice Deficient in Praying	30	2.37
Novice Deficient in Utilizing Resources	28	2.54
Novice Deficient in Educ about Role as PN	27	2.56
Novice Deficient in Making a Budget	28	2.57
Novice Deficient in Functioning in an Org.	28	2.75
Valid N (listwise)	26	

In keeping with the analysis of Research Question # 1, the sum of the top two frequencies of the respondents was also examined as seen in Table 4.11. This table gives the highest to the lowest ranking of the summed top two frequencies versus the remaining four frequencies for each skill. Both Tables 4.10 and 4.11 have 'Keeping

Confidentiality' and 'Health Activities' as the two highest, or least deficient of Parish Nursing skills. The skills of 'Making a Budget' and 'Functioning in an Organization' ranked as the two lowest, 2.59 and 3.22 respectively, suggesting that these may be the Parish Nursing skills in which 60 to 69% of novice Parish Nurses are deficient.

Table 4.11

Sum of Frequencies of Perceived Deficiencies of Novice Parish Nurses Ranked as < Than 50 % or 50 to 59%

Parish Nurse Skill	N	Frequency	Percent	Sum of the Frequencies of Deficiencies Ranked as < 50% and 50 – 59%
Deficient in Keeping Confidentiality	30			
Less than 50 %		24	80.0	86.7
50 – 59 %		2	6.7	
Other		4	13.3	
Deficient in Health Activities	28			
Less than 50 %		14	50.0	82.1
50 – 59 %		9	32.1	
Other		5	17.8	
Deficient in Maintaining a Documentation System	30			
Less than 50 %		10	33.3	76.6
50 – 59 %		13	43.3	
Other		7	23.3	
Deficient in Making an Assessment	28			
Less than 50 %		12	42.9	71.5
50 – 59 %		8	28.6	
Other		8	28.6	
Deficient in Working w/Volunteers	29			
Less than 50 %		13	44.8	68.9
50 – 59 %		7	24.1	
Other		9	30.9	
Deficient in Spiritual Caregiving	29			
Less than 50 %		10	34.5	62.1

50 – 59 %	8	27.6	
Other	11	37.9	
Deficient in Educating about Role as Parish Nurse	27		
Less than 50 %	6	22.2	59.2
50 – 59 %	10	37.0	
Other	11	40.7	
Deficient in Praying	30		
Less than 50 %	12	40.0	56.7
50 – 59 %	5	16.7	
Other	13	43.3	
Deficient in Utilizing Resources	28		
Less than 50 %	8	28.6	53.6
50 – 59 %	7	25.0	
Other	13	46.5	
Deficient in Making a Budget	28		
Less than 50 %	9	32.1	50.0
50 – 59 %	5	17.9	
Other	14	50.0	
Deficient in Functioning in an Organization	28		
Less than 50 %	9	32.1	46.4
50 – 59 %	4	14.3	
Other	15	53.7	

Note. Responses are grouped for the 1st rank (Less than 50%), 2nd (50 – 59%) Deficient and Others which includes 3rd (60 – 69%), 4th (70 – 79%), 5th (80 – 89%), and 6th (90 – 100%) Deficient

Interpretation 2

The data from tables 4.10 and 4.11 support the integrity of the training of novice Parish Nurses in the eleven selected Parish Nursing skills. ‘Keeping Confidentiality’ again ranks the highest, but it still has room for improvement. As one respondent commented, “Maintaining confidentiality is important to keep the Parish Nurse role from becoming a gossip center.” Another stated, “PN’s [Parish Nurses] may need to

learn more ‘tricks of the trade’ for maintaining confidentiality when ministering in a highly visible component of the church’s ministry.”

Being deficient in the Parish Nurse skill of ‘Functioning in an Organization’ was ranked the lowest on both tables. Respondents offer some clarifying comments. “It takes a few years to figure the structure of the church and what relationship it will be...” “Churches don’t understand the role or advantages of having a health care professional in the congregation.” So learning to function in an organization can be influenced by specifics to the church and this, in turn, may not be possible to acquire from the Basic Parish Nursing training course. Although novice Parish Nurses are not grossly deficient in the Parish Nursing skills in general or in a particular skill, respondents still felt deficiencies in novice Parish Nurses.

Research Question # 3

The third Research Question for this study was: *What skills do Parish Nurses perceive as important for Parish Nurse training to develop further.* Respondents were asked to rank the importance of the need to add more training for each of the 11 Parish Nursing Skills. Ranking options were from ‘Of Utmost Importance’ to ‘Not Important’ on a six point Likert scale. When looking at the rank order of the means of the responses for the importance of adding training or education for each skill ascending order, a mean nearest to one would show almost complete agreement that adding further training for the skill would be *Of utmost importance*. The response options for this question had the same corresponding numeric value as did the labels as in Research

question # 1. The skill of 'Praying' ranked highest in the importance of adding more education for the skill (mean = 2.16); second was the skill of 'Providing Spiritual Caregiving' with a mean of 2.25 (See Table 4.12).

Table 4.12

Means of Need for more Education in Ascending Order

Parish Nurse Skill	N	Mean
Need more Education in Praying	32	2.16
Need more Education in Spiritual Caregiving	32	2.25
Need more Education in Functioning in an Org.	31	2.29
Need more training in Education about Role as PN	32	2.34
Need more Education in Documentation Sys	32	2.41
Need more Education in Making an Assessment	31	2.45
Need more Education in Utilizing Resources	32	2.50
Need more Education in Working w/Volunteers	32	2.69
Need more Education in Keeping Confidentiality	32	2.72
Need more Education in Health Activities	32	2.72
Need more Education in Making a Budget	32	3.19
Valid N (listwise)	31	

The skill with the highest group mean would be ranked the highest in needing additional education. The highest mean was the need for more education in the skill of 'Praying'. Praying with a person is a component that differentiates Parish Nursing from nursing in general. The majority of nurses are not known to pray with their patients as part of caring for them. So this is a skill that needs more learning and practice, even for well experienced nurses. The respondents echo this feeling. "This may not be something nurses are comfortable doing, esp. praying with their patients." "This is essentially what sets PN [Parish Nursing] apart from other nursing."

The second highest mean was the need for more education in 'Spiritual Caregiving'. One of the respondents pointed out, "This is a huge part of what we do...and the reason why so many nurses are excited about congregational nursing." A skill valued in this way would also be highly valued in having novice Parish Nurses well trained.

The skill of 'Making a Budget' (3.19) ranked the lowest on Table 4.12. As stated earlier, if one has little or no money in a budget, more training in making a budget has a low priority. The second lowest skill in need of more education was the skill of providing Health Activities for the congregation. This skill is commonly found in other areas of nursing. One respondent commented, "All PN's (Parish Nurses) are nurses before they become PN's. There should already be a level of expertise in health promotion." If this respondent's sentiments reflect the perception of the study respondents, then this skill would rank low on the list of skills that would require more training for novice Parish Nurses.

As with Research Questions 1 and 2, the sum of the top two frequencies of the respondents was examined; (see Table 4.13). This table gives the highest to the lowest ranking of the summed top two frequencies for each skill. Again, when the sequence of the skills closely resembles that of the means as in this case, it serves to strengthen the research findings.

Table 4.13

Sum of the Frequencies for the Need to Add More Education for the Parish Nurse Skill Ranked as 'Utmost' or 'Highly Important'

Parish Nurse Skill	N	Frequency	Percent	Sum of the Percents ranked as Utmost and Highly Important
Need more Education in the skill of Praying	32	12	37.5	68.8
Of Utmost Importance		10	31.2	
Highly Important		10	31.2	
Other				
Need more Training in Education about Role as PN	32			68.7
Of Utmost Importance		5	15.6	
Highly Important		17	53.1	
Other		10	31.2	
Need more Education in Functioning in an Organization	31			67.8
Of Utmost Importance		6	19.4	
Highly Important		15	48.4	
Other		10	32.2	
Need more Education in Spiritual Caregiving	32			65.6
Of Utmost Importance		10	31.2	
Highly Important		11	34.4	
Other		11	34.4	
Need more Education in Keeping Confidentiality	32			

Of Utmost Importance	11	34.4	59.4
Highly Important	8	25.0	
Other	13	40.6	
Need more Education in Maintaining a Documentation System	32		
Of Utmost Importance	8	25.0	59.4
Highly Important	11	34.4	
Other	13	40.6	
Need more Education in Health Activities	32		
Of Utmost Importance	2	6.2	56.2
Highly Important	16	50.0	
Other	14	43.8	
Need more Education in Working with Volunteers	32		
Of Utmost Importance	2	6.2	56.2
Highly Important	16	50.0	
Other	14	43.7	
Need more Education in Making an Assessment	31		
Of Utmost Importance	2	6.5	54.9
Highly Important	15	48.4	
Other	14	45.2	
Need more Education in Utilizing Resources	32		
Of Utmost Importance	10	18.8	53.1
Highly Important	11	34.4	
Other	11	46.8	
Need more Education in Making a Budget	32		
Of Utmost Importance	1	3.1	31.2
Highly Important	9	28.1	
Other	22	68.7	

Note. Responses are grouped for the 1st rank (Utmost), 2nd (Highly) Important and Others which includes 3rd (Moderately), 4th (Somewhat), 5th (Less), and 6th (Not) Important to add more Education for the Parish Nursing skill.

For both Tables 4.12 and 4.13, the highest Parish Nursing skill ranking as needing more education was found to be the skill of 'Praying'. With a group mean of 2.16, respondents perceive that it is highly important to add more training for this skill. The

tables differed for the second highest skill recommended for more training. In table 4.12 of means the need for more training is 'Spiritual Caregiving' is ranked second at 2.25 or 'highly important'. Many comments alluded to the fact that 'Spiritual Caregiving' is often reserved for the clergy of the church. Under these circumstances, it can be challenging to achieve compatibility between the clergy's established role and the new role of the Parish Nurse. As a matter of clarification, the role of the Parish Nurse is never meant to interfere or compete with another's (the clergy's) role, but rather to work harmoniously and assure that the spiritual needs of the congregation are met.

For Table 4.13, the second highest sum of frequencies of perceived need for more training is the skill of 'Educating the Congregation about the Role as a Parish Nurse' at 68.7. This is only 0.1 lower than the highest skill of 'Praying'. Again the respondent comments add clarification. "I feel it comes as you practice in the congregation, because it is difficult to explain all that you can do or want to do as a Parish Nurse." Another comment, "It will be a great help in educating the congregation and pastor before you even begin such a program."

Interpretation 3

As would be expected, the need for educating novice Parish Nurses is ongoing, and this method of analyzing the Parish Nursing skills helps to see the priority value of the most desired Parish Nursing skills. Ten of the eleven of the Parish Nursing skills have a sum of the top two frequencies exceeding 50 percent, reflecting the high value in educating the Parish Nurses about these essential skills. The skill of making a budget has

the lowest need for more education about the skill, but having a group mean of 3.19, it is still perceived to be at the moderately important level of need. Life long learning is acknowledged throughout the Basic Preparation Curriculum for Parish Nursing.

More on the Parish Nursing Skills

Following each set of three questions about the eleven Parish Nursing skills was a textbox asking for comments about the skill. Respondents frequently added narrative comments. These comments give voice to the respondents, freely and without any controls. The comments are presented here by each of the Parish Nurse skills. Many comments were a form of affirmation regarding the perceived importance of the skill; others described common problems such as nurses not being comfortable with the skill. Some comments described challenges for the Parish Nurses in carrying out the skill.

Functioning in the Organizational Structure of the Church

The comments for this Parish Nursing skill centered on two themes, 1) the Parish Nurse not feeling needed by the congregation and 2) the struggles of the novice Parish Nurse within the church hierarchy. Regarding the Parish Nurse not feeling needed, one respondent stated, “Churches don't understand the role or advantages of having a health care professional in the congregation.” Another nurse pointed out that the “Congregation does not take it (Parish Nursing) seriously.” A novice explained her efforts, “It seemed that all that the congregation wanted was blood pressure monitoring... and with me being a novice, it [the Parish Nurse Ministry] just didn't develop.” Initiating the Parish Nurse ministry takes time so “the nurse will need to allow

for deliberate assimilation into the community” and that is “IF (caps original) they allow a program to develop.” Another stated her problem was just getting the “buy in from the congregation to get the program established.” Sometimes the congregation does not perceive a need for the Parish Nurse, for example, one Parish Nurse stated “statements I often heard were ‘when I need healthcare I just go to my doctor,’” and another respondent echoed, “Members do not feel the need for my services.”

On the other hand, an expert Parish Nurse readily gave a list of what is needed in this skill, “relationship building, conflict resolution, role/responsibility to clergy, building rapport w/outside resources”; in a word, eliminating ‘turf’ issues. To do all of this another Parish Nurse felt that this skill is “dependent on the Parish Nurse's faith, creativity, and knowledge of the needs of the parish and community. He/she must possess good communication skills and never forget that he/she is a servant first.” Other respondents realized “that the organizational structure is so different in each church...so our voluntary functions will vary considerably,” and there may be “some difficulty defining the placement of the parish nurse in the organizational structure (chart).” Fitting into the organizational chart may take time as the Parish Nurse begins “to fit into the dynamics of the church and [gain] acceptance and understanding of the role of the congregants and leaders.” Another felt it might take “a few years to figure the structure of the church and what relationship it will be”; and “sometimes the process is slow.” A wise Parish Nurse proposed this solution, “It would be nice if pastoral schools included a class on, “What a Parish Nurse can do for my Congregation.” To add to that, clergy support determines how the Parish Nurse “function(s) and if you have the support to

function as you should.” Another respondent felt it may be helpful to have “more training on how to approach the pastoral staff.” And finally an experienced Parish Nurse shared her insights, “I have been through 3 senior pastors in six years. I have had to negotiate various beliefs about health, the role of minister, the ability to share roles, ability to communicate etc. It is probably the most frustrating part of the job. The politics are amazing!”

Making an Assessment of the Church's Health Needs

Comments for this skill reflected the value of making an assessment and some of the associated challenges. A primary value was the need for assessment because as one respondent simply stated, “it is very important to know the needs of God's people,” and another pointed out “you must do an assessment to be able to determine what is needed, not just what your pastor wants you to do.” One Parish Nurse felt assessment “seems to be a little easier” but another felt just the opposite, “This will be one of the more difficult skills for the Parish Nurse to undertake.” The difficulty in assessing the needs may be “because many people don't allow or voice their needs.” An experienced Parish Nurse posted that an assessment “has been done on several occasions with poor returned input.” One Parish Nurse worried that “this is one of the essential roles and unfortunately with so many hospitals sponsoring parish nurses, it is often overlooked.”

Since the survey asked if more education was needed for each of the Parish Nursing skills, the comments also addressed this. One respondent complimented “the basic course did an excellent job in helping us with the necessary tools used to make an

assessment of our church's health needs.” Another knowledgeable Parish Nurse agreed, “Most Parish Nursing courses do an acceptable job of teaching population assessment skills. They do not, however, always expound upon or review community health concepts such as windshield surveys and participatory action research, which are valuable adjunct skills in making a comprehensive assessment of a church or parish's health needs.” Several respondents felt “well-prepared” or “this was adequately covered in the course,” but one felt “more questionnaire examples could be handed out.” Another respondent felt “one can always learn more, and share successes and failures.”

Educating the Congregation in Understanding the Role of the Parish Nurse

In starting up a Parish Nurse ministry, first things need to be done first. A respondent pointed out that it is “a great help in educating the congregation and pastor before you even begin such a program.” Another respondent felt that “most novice Parish Nurses do an adequate job of communicating their role and importance to members of the faith community.” Several respondents felt that the beginning Parish Nurse needed the support or “buy in” of church administration. One summed it up stating, “Education is a BIG key!!!!”(caps and exclamation points original). One Parish Nurse had already tried to educate her faith community with very limited success. She writes “not one parishioner had ever heard of a Parish Nurse, so I had to do a lot of explaining just what a Parish Nurse does.”

Education is on-going and certainly not accomplished in the first weeks for the Parish Nurse. As one respondent wrote, "I feel that comes as you practice in the congregation, because it is difficult to explain all that you can do or want to do." Nevertheless, there are limits to what a Parish nurse can and cannot do, and another respondent agrees that it "is sometimes difficult to relay to the whole congregation." Another Parish Nurse states she has "educated individuals as I have worked with them, but educating the congregations relies to a degree on the political structure and the senior pastor." As for more need for education on this Parish Nursing skill two respondents felt "that the issue of educating the congregation in understanding the role of the Parish Nurse was stressed very well in our Parish Nurse Course, "but we could use more tools to promote our work to the congregation."

Making out a Parish Nursing Budget

Comments about budget fell on one end or the other of a dichotomy, the 'haves' and the 'have nots'. For those that have a budget, one Parish Nurse pointed out that if it is not adequate then "either the congregation will not have the full advantage of having a Parish Nurse ministry or the Parish Nurse will get in the habit of taking money out of her/his own pocket and may get burned out quicker." The start-up year is a bit complicated in that the needs are not known "until one goes thru the year as piloting the program" and "The first year has set up cost differ from other years," or "until needs are known, it's hard to figure a budget." In this instance education about the Parish Nurse role is essential, as one respondent noted "educating the congregation about the

importance of Parish Nursing is necessary before they will consider giving the program money.”

Even so, funding in churches can be very limited. One Parish Nurse of eight years “was allocated \$1000.00 and nothing budgeted since that time.” For another Parish Nurse, “Most of what I do is voluntary and there is no need for a budget,” but this same nurse had hope for the future, “If we get larger that will probably change.” Another Parish Nurse deals with her non-budget by “If anything is needed, I petition the members.” Two other budget-less Parish Nurses felt “It is the least thing that I have to worry about” and “Expenses are minimal and not a priority,” or “I didn't have a budget, so this doesn't apply.” Having no budget is a pervasive problem for Parish Nurses. In the landmark study by Solari-Twadell (2002), “30% ($n = 349$) had no access to budget funds.” In addition, the Solari-Twadell (2002) study found that “31.3% of Parish Nurses are paid for their services and 67.9% are not paid (p. 89).

Regarding increasing more education about making a Parish Nursing budget, one respondent felt it “may not be emphasized in certain faith communities when Parish Nurses are volunteers, and resources are provided/ donated.” Even in this instance another Parish Nurse cautioned that “in a volunteer model, a budget line should be established to recognize this unique ministry.” One respondent summed up a common feeling, “Money is important but it is the least important of all items together.”

Maintaining a Documentation System

In general the comments about maintaining a documentation system reflected its importance to the Parish Nurses along with wanting more examples and keeping the system simplified. Regarding importance one Parish Nurse pointed out that “Documentation is important in all areas of nursing, so this should not be any different,” and “an accurate account of all programs can be used as an assessment tool for future ideas.” Another respondent pointed out the need for documentation and communication, “very important to be able to have documentation of all aspects of Parish nursing and to be able to relay and communicate with others about items.” Similarly, documentation is “Important to the Parish Nurse to remember her visits and what they consisted of.” Two respondents pointed out that documentation “can also be important for gathering data,” and “data collection is important for accountability.”

Several comments focused on the desire for more examples of documentation forms. As one advanced beginner Parish Nurse requested, “provide as many documentation samples as possible so the new Parish Nurse doesn't feel like she/he needs to recreate the wheel.” Likewise, a novice Parish Nurse felt that “receiving samples of flow sheets used successfully by other congregations is always an asset to the novice Parish Nurse.”

For more education on documentation, one Parish Nurse felt that “this is an area that needs more emphasis, because not sure documentation is being done by all Parish Nurses.” Another respondent offered that “some things are difficult to document when interactions are informal.” This difficulty in documenting informal interactions may also stem from the fact that the most common intervention used by Parish Nurses in the

Solari-Twadell (2002) study was “presence” or “being a presence” for a person.

Documenting presence may be difficult for novice Parish Nurses. One respondent summed up the general feelings about documentation, “This is critical to our ministry. This is how we document what we do.”

Maintaining the Confidentiality of Everyone with Whom the Parish Nurse Works

Without a doubt the survey respondents felt that maintaining confidentiality should be a given for any nursing professional, especially in the light of The Health Insurance Portability and Accountability Act (HIPAA) legislation in the last two decades. This expectation is reflected in many of the comments such as “confidentiality is of upmost importance and most all nurses understand this”; “This is crucial”; “a given”; “This we know” and this is “is what we do and this is no different than any other nursing job.”

There were other comments that revealed deeper reflection on the part of the respondents. One novice Parish Nurse pointed out “Confidentiality is vital to the success of Parish Nursing. A fellow church member needs to know that the nurse will not repeat any issues to other members.” Other respondents could see this same risk, “The parish nurse will need to be very astute and set strict boundaries. If the encounters have the potential of getting enmeshed or involve very personal/family issues, the nurse must refer the person/family to an appropriate agency or speak with the pastor about the situation.” Because “maintaining confidentiality is important to keep the Parish Nurse role from becoming a gossip center” it may be necessary for Parish Nurses to learn more

"tricks of the trade," when ministering in a highly visible area." In making referrals, Parish Nurses and other health professionals need to disclose some information and other information is not necessary to share. One respondent suggested that more guidelines may be needed when "sharing information after referrals."

Finally, one Parish Nurse had an unexpected situation that is totally the opposite of her training and expectations. She writes, "Most of my 'elderly' (over 80) ask questions and don't seem to care if their church peers know what's happening to them. They usually already know. This has been an area that has been hard for me."

Providing Health Activities for the Congregation

Like maintaining confidentiality, providing health activities was a given expectation of most respondents as "All Parish Nurses are nurses before they become Parish Nurses. There should already be a level of expertise in health promotion when they come to the course. I feel that this should be easy for most nurses" and "have a lot of knowledge from their past jobs and skills to relate well with others."

Aside from knowing about health activities, the respondents expressed a high value of importance for the skill. For example, "Healthy proactive activities keep people informed and healthier"; "This seems to be the best avenue for attending to broad-based needs"; "Most of us are well acquainted with possible health activities for our congregations"; "there are a great number of resources to offer this," and "I suspect this is done by most."

For more education on the skill, two respondents wanted more information, “We need more of this,” and “Always need good ideas.”

Praying with Others

The themes of the comments regarding praying with others centered on the importance of prayer, getting comfortable praying with others in their presence and the variety of ways to pray. For the importance of prayer, respondents said prayer is “one of the most important aspects of Parish Nursing”; “Comes with the calling to be a Parish Nurse,”; “This is essentially what sets Parish Nursing apart from other nursing,” and “This is the main ingredient in the wellness of a patient.” Two other Parish Nurses felt that prayer “Is helpful to the parishioners and generally well received,” and prayer is sometimes “not seen as an aspect of the care given to others but [it] should be.”

Why are Parish Nurses not comfortable praying with others? Two respondents suggest, “It is a skill one learns from their faith not just a course topic; also development happens as one continues to use prayer in their ministry,” and “Praying skills can be learned, but primarily by doing.” Many respondents addressed the need to acquire a comfort level when praying with others, “Not all people have a comfort level with this venue”; “This may not be something nurses are comfortable doing, especially praying with their patients”; “The more you do it the easier it becomes,” and praying “will come with comfort in the role.” An experienced Parish Nurse had this to say about the fear of praying, “Parish Nurses need to learn that there is a difference in “praying with” and “praying for” a client. Parish Nurses need to be bold enough to “pray for” a client while

he or she is still present with them, rather than at some other time. Too many Parish Nurses seem afraid to pray directly with clients, almost as if they carry the taboo of the secular hospital workplace over into the sacred church environment. This needs to change. Parish Nurses must become expert pray-ers!"

Experienced Parish Nurses know there are a variety of ways to pray with a person in their presence, "Prayer is needed by all and there are many ways to pray, sometimes with words and always with actions." Other Parish Nurses offered, "I believe the personal style of praying is the best," and "It is also about silence as prayer and Radical Presence - not just words used. I believe it is cultivating a contemplative presence that is a gift given not earned."

Working with Volunteers

Rev. Granger Westberg, the founding father of the Parish Nursing concept placed working with volunteers on his original list of roles of the Parish Nurse. Parish Nurses can do many things in service to the faith community, but others can help the Parish Nurse. When volunteers assist the Parish Nurse it allows for better use of the Parish Nurse's time and the volunteer gains a feeling of worth and a part of the ownership of the Parish Nurse ministry. It is a win-win situation and this principle is stressed in the Parish Nurse's training. The respondents' comments reflect this principle, "A solid and responsible group of volunteers will be a tremendous boost for any activities planned by the Parish Nurse," and "Communication and leadership skills are important. Need to know how to inspire others, so will get volunteers." One Parish Nurse cautioned, "As

nurses we think we should do it all,” and “One person cannot do all things alone, others are always needed and usually want to get involved.” One respondent felt that “Most Parish Nurses I know work well with others, including volunteers,” and “It’s about working with people, one’s people skills.”

Working with volunteers is not without problems. One respondent felt that “The best volunteers are frequently tapped on many occasions,” and it is “Often difficult to recruit effective volunteers”; “[it] requires a certain amount of tact, organizational skills in working with people. Not everyone is comfortable or gifted in this area.” There were no comments about the need for more education regarding working with volunteers.

Utilizing Local, Regional, National, and Denominational Resources

The responses on utilizing resources focused on two themes, 1) affirmations that there are adequate resources and 2) being a good steward of those resources. One novice was very clear about utilizing resources, “It is always good to use resources that have already been developed. No reason to re-invent the wheel. It is important to network with other Parish Nurses. You can learn a lot through their experiences.”

Most respondents commented about the availability of resources, “We had many local and other resources given to us during the course. All we need do is follow up on them”; “One needs a discerning mind with allllll [extra ‘L’s original] the resources that are out there,” and “Our local resources are usually adequate.”

Being good stewards was important to several respondents, “[the] skill of “asking” and how to acknowledge with “thanks” for resources provided should be

included”; “how to be a steward of information that is so easily accessed by all,” and “The more you know and the more one can share resources, the better the organization will be.”

Education about utilizing resources was mentioned by two respondents, “I feel that this was well covered in my Parish Nurse Course,” and “[the] nurse must keep up on the areas to contact for her people.”

Providing Spiritual Care for Members of the Congregation

The spiritual care component is a unique characteristic of Parish Nursing. The respondents’ comments focused on three themes: 1) the importance of spiritual caregiving, 2) having or the lack of a collaborative relationship with the clergy in providing spiritual care, and 3) the Parish Nurse’s knowledge and comfort level with spiritual caregiving.

Providing spiritual care was very important to many of the respondents, “This is a huge part of what we do and the reason why so many nurses are excited about congregational nursing. A key element!” and “That’s why we take the basic course in the first place, we want to make a difference in our church community. I think we are already very focused on that aspect”; “We are servants first and with faith, hopefully, we will care spiritually for all of God’s people.” Other experienced Parish Nurses tie spiritual caregiving to prayer, “Spiritual care is not complete unless the Parish Nurse can also provide comfort and intervention through active PRAYER (caps original),” and to all care, “Spiritual message should be imbued with all care.”

Spiritual care traditionally has been the domain of the clergy, so another professional providing spiritual care can create 'turf' issues rather than the hoped for collaboration. Several respondents wrote about this dilemma, "Many preachers feel this is their territory and don't want share this"; "Depends on denomination and whether or not clergy/pastor 'allows' the Parish Nurse to be spiritual caregiver." One nurse felt differently, "The nurse needs to understand that the pastor/minister holds this domain for the community." Some parishioners also felt that spiritual caregiving is the clergy's domain, "most parishioners expect the minister to provide for the spiritual care of members." One respondent suggested this remedy, "Congregations and pastors need to be educated re: roles of Parish Nurse prior to the nurse taking the class; then being frustrated because she/he cannot function as anticipated." Clinical Pastoral Education (CPE) was also suggested, "I believe that pastoral care and spiritual care is ongoing learning and not just taught in a course. CPE is critically needed by nurses working in congregations and with people; we have not had this formational training," and "The pastor is very important for Parish Nursing and must be involved to help in providing spiritual care." As with praying with others, some respondents felt that nurses "may not readily be comfortable with giving spiritual care," and "Not all people have a comfort level in this area"; "[giving spiritual care] is a skill that has to be practiced in order to feel comfortable with it."

Comments about Other Parish Nursing Skills

The very last request on the survey was a textbox asking for “Comments about other important Parish Nursing skills.” Of the nine comments there were no duplicates which in itself reaffirms the significance of the eleven skills that were used in the survey. One experienced Parish Nurse wrote about two skills, self care for the Parish Nurse and continuing education. Both of these skills were in the list presented to the content experts, but were eliminated. Self care is also a module in the core curriculum. The nurse writes, “Two very important and needed skills: SELF-CARE [caps original] and Continuing Education!! Parish Nurses must make sure that their own souls and spirits are nurtured, and that the Parish Nurse is in right relationship with God, or the ministry will flounder. Continuing education in spiritual care/ spirituality as well as one or more nursing specialty areas is crucial to remaining clinically relevant and professionally competent. Too many Parish Nurses, it seems, do little in the way of continuing education once the basic preparation has been completed.”

There were two similar suggestions, one just stated, “Network” and the other, “Greater exposure to regional, state or national networking.” Another respondent had mentioned ‘Radical Presence’ in the section on prayer, but explains further, “Radical Presence - Mindfulness - Being a Presence for people in silence, accepting the helplessness of our help - let go of busyness, finding the sacred in life in ordinary things.” Another skill that was mentioned was “the skill of listening is important and frequently it is not used as much as it should be.”

The other comments are listed here:

- recruitment for health cabinet
- the use of mentors should be addressed
- I think that counseling services, perhaps with an additional certification for counseling should be added.
- a "generic" example of how a nurse can create a proposal to go before the church to introduce the Parish Nurse program
- a power point presentation for church leadership, and to the other nurses to start a Parish Nursing Program.

This list has single items that are desirable but not a skill with broad impact for all Parish Nurses to practice. Further it does not propose additional skills that need to be added to the Parish Nurse core curriculum.

Chapter 5 Discussion

Gap in Learning Needs

DeSilets (2006) writings identified that in defining the gap between where the learner's knowledge is and where it needs to be, there may be more than just a simple difference. DeSilets points out that in assessing learning needs, there is difference between what a learner needs to know, and what is nice to know or ought to know. So the proverbial question here asks: are novice Parish Nurses getting what they *need to know* from the Basic Preparation Curriculum for Parish Nursing. Comparing the responses of 'expert' and 'proficient' Parish Nurses (Benner's 1984 terms) to those of the novices may provide the answer. In doing so, this would hold the opinions of expert Parish Nurses as the standard for making this judgment, rather than the Parish Nursing faculty. Table 5.1 was constructed to refine the data with this question in mind. For each Parish Nursing skill regarding the importance of the skill, frequency of responses for the two highest options ('of utmost and Highly Important') were grouped and separated from the remaining four options. These responses were further separated into three groups, i.e., the top two Benner levels of expertise, expert and proficient; the competent level; and the bottom two levels, the advanced beginner and novice. The last column of Table 5.1 is the difference when the percent of the third group (the advanced beginner and novice) was subtracted from the first group (expert and proficient).

Table 5.1

Difference Between the sum of the Frequencies for the Importance of the Parish Nurse Skills Ranked as 'Utmost' or 'Highly Important' between Experts and Novices

Parish Nurse Skill	N	Expert & Prof.	Competent	Adv. Beg & Nov-ice	Difference of percent between Expert to Novice
Keeping Confidentiality	32				
Utmost & High Importance		100%(9)	100%(12)	100%(11)	0
Other		0	0	0	
Skill of Praying	32				
Utmost & High Importance		100%(9)	92%(11)	81%(9)	19
Other		0	1	2	
Educate about Role as PN	32				
Utmost & High Importance		89%(8)	83%(10)	64%(7)	25
Other		1	2	4	
Spiritual Caregiving	32				
Utmost & High Importance		78%(7)	75%(9)	73%(8)	5
Other		2	3	3	
Working with Volunteers	32				
Utmost & High Importance		100%(9)	67%(8)	64%(7)	36
Other		0	4	4	
Providing Health Activities	31				
Utmost & High Importance		78%(7)	67%(8)	73%(8)	5
Other		2	3	3	
Maintain Documentation	32				
Utmost & High Importance		44%(4)	67%(8)	81%(9)	-37
Other		5	4	2	
Making an Assessment	32				
Utmost & High Importance		67%(6)	67%(8)	64%(7)	3
Other		3	4	4	
Utilizing Resources	32				
Utmost & High Importance		67%(6)	58%(7)	55%(6)	12
Other		3	5	5	
Function in an Organization	32				

Utmost & High Importance		44%(4)	50%(6)	45%(5)	-1
Other		5	6	6	
Making a Budget	32				
Utmost & High Importance		56%(5)	33%(4)	18%(2)	38
Other		4	8	9	

Note. Responses are grouped for the 1st rank (Utmost), 2nd (Highly) Important and Others which includes 3rd (Moderately), 4th (Somewhat), 5th (Less), and 6th (Not) Importance of the Parish Nursing skill.

To interpret Table 5.1, the differences of perceived importance are very little except for three skills: Working with Volunteers, Maintaining a Documentation System (negative) and Making a Budget. It is possible that the expert Parish Nurses have long learned that this ministry is not to be done solo, and eliciting the help of volunteers was significantly more important to them. In the Solari-Twadell (2002) study, 82% of the respondents ($n = 1161$) had access to volunteers and some Parish Nurses were responsible for the coordination of and training of the volunteers.

For the skill of Making a Budget, there is a large difference, even though this skill has a lower ranking than most of the other Parish Nursing skills. The financial aspect was a dilemma during the establishment of the Parish Nursing concept for Westberg (1999) when the financial aspect of a paid staff position was proposed to be put added to the church budget. More and more Parish Nurses are beginning this ministry as volunteers themselves and meet the same resistance as did Westberg. In many churches being a volunteer means no budget or and when something is needed, it is dealt with by soliciting donations for the express cause. Thus making a budget is the lowest in importance for the volunteer Parish Nurse.

On the other hand, some expert Parish Nurses may still value making an account of whatever funds the ministry utilizes, even if such is donated by request. If an accounting of all dollars spent and items used is clearly stated in the Parish Nurse's annual report, church financial officers can quickly see over time what has been spent and accurately estimate what amount needs to be budgeted, should the Parish Nursing ministry become a line item at some future point.

The difference of opinion regarding Maintaining a Documentation system may be a delight to the Parish Nurse Educator's eye. As this ministry matures over time, it has become increasingly obvious to the International Parish Nurse Resource Center that documentation is very much needed to substantiate the need for grants, and even justify what the volunteer Parish Nurse is doing. To illustrate the difference, in the author's experience, the Parish Nurse training available in 1994 did not stress as much on documentation as does the current Basic Preparation Curriculum for Parish Nursing available through the IPNRC. Parish Nursing faculty may have the satisfaction of knowing that value of documentation is gaining importance.

Future Applications

Although it was not intentionally planned, this study, albeit small, is in the unique position of researching a before and after effect. On August 1, 2009 the International Parish Nurse Center released the latest revision of the Basic Parish Nursing Preparation Course curriculum to 65 of the 130 Educational Partners. There will be an 18 month window of phase out time after which the 2004 edition of the curriculum

should no longer be used. It is possible now that the same survey could be administered to a sample or samples of Parish Nurses two to four years from the time of this study. There is one readily noticeable limitation in this plan in that this study did not confirm whether or not the survey participants took the Parish Nursing curriculum developed through the International Parish Nurse Resource Center. It is quite likely that all the Parish Nurses did have their training with the IPNRC curriculum, but even so, 20 of the respondents would have had to have had the 1998 original edition. Authenticated comparisons may be limited but it would still be of value to study the felt learning needs and feelings of the Parish Nurses.

Application of Findings

Although the sample of Parish Nurses in this study was small, it closely resembles the demographics found in the hallmark study by Solari-Twadell (2002). For the age ranges of the Parish Nurses in this study, more than half (53.1% from Table 4.3) are ≥56 years, and Solari-Twadell reports that the average age of her sample was 55 years. Regarding the highest health care degree completed, 71.9% of the Parish Nurses have a bachelors degree or higher for this study. For Solari-Twadell, 62% had a bachelor's degree or higher.

For the composite scores (Table 4.9), 'Keeping Confidentiality' was rated the highest and that is a characteristic instilled in all nursing schools and an essential in the Florence Nightingale Pledge. 'Praying' and 'Spiritual Caregiving' respectively held the second and third highest composite scores. This finding mirrors the findings of Solari-

Twadell, where she states “Prayer was one intervention most often listed by the Parish Nurse respondents” (Solari-Twadell, 2006, p. 20). Her explanation states that these spiritual interventions substantiate the notion that spiritual care is the hallmark of Parish Nursing practice.

It is not unlikely that novice Parish Nurses were felt to have the least deficiency in Keeping Confidentiality and Health Activities because these skills are analogous to any professional nurse practice. However, the survey showed the highest composite score (least desirable) from Table 4.9 and most deficient from Table 4.10 was felt to be in ‘Functioning in an Organization’ and ‘Making a Budget’. Based on the comments from the respondents, ‘Functioning in an Organization’ is fraught with turf issues, many of which would be specific to the nurse’s church governing body. ‘Making a Budget’ is seldom done by nurses in any health care area, except for some nurse managers. Consequently it is not an essential skill for nurses in general and based on the comments, when a Parish Nurse is given a ‘zero’ budget to work with, making a budget is a moot point.

The greatest need for more education for a skill (Table 4.12) was reported as the skill of ‘Praying’ and second was the skill of ‘Providing Spiritual Caregiving’. However, these means are not all that high, 2.16 and 2.25 respectively, especially since the range of all the means was very narrow, from 3.19 to 2.16. Respondents felt it was somewhat to moderately important to add more training for these skills in the Parish Nursing education course. The value of caring for the spirit is also reflected in the program topics for many Parish Nursing seminars and continuing education programs. It is the author’s

opinion that nursing training in general neglects this area. This is based on the author's experience in teaching at the undergraduate nursing level and her own search for ways to help student fulfill this essential human need in patient care. It may also be that Parish Nurses find themselves with an inadequate repertoire when it comes to spiritual caregiving and hence, the data show a perceived need for more education in this area. The lowest ranking on the need for more education was in 'Making a Budget'. As stated earlier, this is not a skill typically used in nursing and when "more than 65 percent of the current Parish Nurses in the United States are doing the ministry on an unpaid basis" (Patterson, 2003, p. 61), so more education in making a budget is hardly needed.

Learning Has Taken Place

The secondary framework for this study was the *accountability process* proposed by Berardinelli and Burrows (Vella, Berardinelli, & Burrows, 1998). As stated earlier, the six elements of the process are checked by program evaluation. After a program is designed and presented, then learning should take place, but the real crux of the accountability process is when *transfer* (Vella's term) takes place. *Transfer* is essentially a when a program participant puts into action what was learned. In this instance the nurse has learned about the new role of being a Parish Nurse and has returned to her faith community to establish the Parish Nurse ministry; the novice has begun to function in the new role as a Parish Nurse. This study was just one facet to the process of evaluating the *transfer* of the learning from the Basic Preparation Curriculum for Parish Nursing. Study respondents from novice to expert skill levels generally agreed that the

skills being taught in the Parish Nursing training are important, and novice Parish Nurses do not have major deficiencies in the 11 select Parish Nursing skills. The study results showed there is some need to add further education for some of the skills, but there are no major gaps in Parish Nursing education that need to be remedied.

The six elements of the *accountability process* (Vella, Berardinelli, & Burrows, 1998) include:

- Purpose of the education program
- Learner skills, knowledge and attitudes to be developed
- Education program design decisions
- Learning that occurs in the program (*Learning*)
- Changes in job performance (*Transfer*)
- Organizational improvement resulting from the education program (*Impact*)

Ideally, evaluation is embedded in program planning, but these theorists realized that evaluation many times takes place after the program has been developed and presented. This is the case for the Basic Preparation Curriculum for Parish Nursing. The curriculum has been available and taught by IPNRC's now 140 educational partners since 1998, and many Parish Nurses have gone on to successfully establish a Parish Nurse ministry in their chosen faith community. Naturally it is the belief of the Parish Nursing faculty and curriculum editors that the curriculum laid out is their best and most knowing effort. The author was an editor for the 2004 revision of the Basic Preparation

Curriculum for Parish Nursing and the 12 Supplemental Modules that became available in 2008. For the curriculum revision, a formal survey and focus group data were collected from the Parish Nursing Faculty, but there has not been any documented evaluation of the curriculum, particularly an evaluation from the novice Parish Nurses' perspective. This study has accomplished the foundational work needed to launch the evaluation of the curriculum on a larger scale. True the number of education a partners for the IPNRC continues to grow and the number of Parish Nurses is growing exponentially, but increasing numbers is not enough. Evaluation reveals what is being done correctly and it can thus be repeated or continued. Failures or gaps cannot be turned into successes unless the problems have been correctly identified. Only then can an intervention be effective. The young Parish Nursing movement needs to know both the positive and negative findings. Most likely achieving this will fall to the responsibility of the Parish Nursing faculty. It would be an honor and a duty to lead the way!

Recommendations

Establishing an accurate account of the Parish Nurses in Indiana is one area that needs to be achieved for future research in Parish Nursing in Indiana. Achieving this has many factors in that the work currently being done at the Indiana Center for Parish Nursing is done by volunteer Parish Nurse Coordinators. Ms. Peisker's role as President is based on her relationship with the loosely associated Board of Parish Nurse coordinators and her time doing so is a small part of her paid position as Community

Development Liaison at St. Vincent Hospital in Indianapolis. It is hoped that at least a master list of the Parish Nurse roster can be created in the near future.

A second recommendation from this study is to make it known to other interested parties. It will be very important to keep in mind that the sample is very small and generalizations cannot be made on the findings. However the research process was intact and replication and strengthening the method of the study is worthwhile to pursue, especially for novice Parish Nursing researchers. The IPNRC has established a research committee and the final study will be forwarded to them.

A third recommendation is that the study should be replicated to increase the response rate. This is quite possible in working with Flashlight Online. To do this, the original survey at the Flashlight website should be copied and renamed with a Roman numeral "II" added or some indicator to differentiate it as a later study. The entire process with the Letter of Invitation containing a direct link to the second study and the data collected can be done with a more valid sample under more control of the researcher.

Another reason for recommending the replication of the study is based on the fact that the 2009 revision of the Basic Preparation Curriculum for Parish Nursing has been released as of August 2009. This makes it is a realistic option to utilize the survey in this study to assess post 2009 curriculum revision findings against the pre-2009 revisions. A larger study can be especially helpful to the IPNRC in their work.

Limitations of the Study

This study is limited to those Parish Nurses in Indiana who responded to the survey. It is a very small sample ($n = 32$) and cannot be generalized to other populations of Parish Nurses or nurses. This study did not ascertain if the participant had training which utilized the curriculum developed through the International Parish Nurse Resource Center or not, and if so, which edition was used. When studying learning needs, it might be important to ask the question.

Any learning assessment is self limiting in that it is dated and specific to the population studied. Therefore future research consumers need to be mindful of this fact when utilizing a study such as this. Nevertheless, repeat studies can provide the most current data and over time can illustrate trends in the findings. Research is probably the most effective means for a new nursing specialty to mature and achieve lasting outcomes.

Conclusion

Parish Nurses have a high regard for their Parish Nursing training and feel adequately prepared for the expectations of their new role. In all, the rankings for the importance of the Parish Nursing skills studied were considered to be from moderate to of utmost importance, the percent of deficiencies in the skills of novice Parish Nurses was felt to be no higher than 60% for any of the skills, and the need for more education for the skills was ranked at moderate to highly important to add more training in the Parish Nursing course. This study is descriptive in nature and offers a clear affirmation

that the preparation for Parish Nurses does meet the learning needs of novice Parish Nurses based on the responses of knowledgeable Parish Nurses from all levels of expertise; from the novice to the expert. The survey prepared here may be useful for repeat studies of the learning needs of Parish Nurse in the future.

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Appendix A: Obtaining Permission

(2 pages)

From: Kelly Peisker [mailto:KVPeiske@stvincent.org]
Sent: Monday, May 19, 2008 3:55 PM
To: icpn2005@sbcglobal.net; sicumcpn@aol.com; Tormoehlen, Lucy J
Subject: Re:

Lucy,

We have agreed the best e-mail avenue is to send it to the center. Michele will forward it to all of the board and then the board sends it out. We cannot keep up with the ever changing e-mail addresses of everyone. But, would be happy to help with your dissertation.

Kelly

Kelly V. Peisker
Community Development Liaison
& Parish Nurse Coordinator
St. Vincent Health
317-338-8457
kvpeiske@stvincent.org

>>> "Tormoehlen, Lucy J" <ltormoeh@iuk.edu> 5/19/2008 3:00 PM >>>
Dear Kelly and Michele,

I am in the proposal stage of writing my dissertation on making an assessment of the learning needs of novice Parish Nurses during the time when a Parish Nurse ministry is being established. My survey will ask participating Parish Nurses what they believe to be the most important skills needed in setting up a Parish Nurse ministry, what percentage of novice Parish Nurses are *deficient* in each skill, and what skills need added emphasis in the Parish Nurse training course. I am limiting my list of skills to 10, so that the survey should only take about 15 minutes for the 30 questions.

The survey is anonymous and will have the approval of the Institutional Review Board at Ball State University. I would like to request that all Parish Nurses in Indiana be

invited to take this survey, because I think their opinions are valuable. So I am inquiring if I could have permission to survey the Parish Nurses from The Indiana Center for Parish Nursing? If this is possible, how best should I go about this? Maybe the easiest would be for me to forward the Letter of Invitation (see attachment) to the ICPN and have you send it out. The letter would contain the live web-link to the survey. I would then need to send a Reminder letter (see attachment) about 3 weeks later. I can make paper versions of the online survey that I will pay the postage to send and return the survey to anyone not using e-mail.

If you have questions, you are welcome to call me at (765) 631-2108 or e-mail ltormoeh@iuk.edu You may also contact my Dissertation Chair, Dr. Joe Armstrong at (765)285-5475 or JARMSTRONG@bsu.edu .

Please let me know if this is possible and if so, how to proceed (after I get all the approvals at BSU).

Thank you so very much.

Sincerely,
Lucy Tormoehlen, Graduate Student
Ball State University
Muncie, Indiana

Appendix B: Letters

Letter of Invitation

From: Lucy Tormoehlen

To: _____

Subject: A Learning Needs Assessment of Parish Nurses

Dear Parish Nurse,

I am writing to request your participation in a survey as part of my dissertation, about the learning needs of novice Parish Nurses during the time when a Parish Nurse ministry is being established. Registered nurses who have completed a Parish Nurse training course are asked to take the survey. Your participation and honest answers are crucial in assessing what are the most important skills needed in setting up a Parish Nurse ministry, what percentage of novice Parish Nurses are *deficient* in each skill, and what skills need added emphasis in the Parish Nurse training course. The study results will help in the training for Parish Nurses.

The survey takes about 15-30 minutes and is completely voluntary and anonymous. No personal identifiers will be used on the data, and no password is needed. You may withdraw anytime without penalty by clicking the X in the top right of the screen. To start the survey, click on the following link:
www.tLTgroup.org/Flashlight?FLO Please click "Send Survey" at the end to submit your responses.

This research has the approval of the Institutional Review Board from Ball State University. Completing this survey constitutes your consent, but if you have any questions or need help, you may contact me, Lucy Tormoehlen, at ltormoeh@iuk.edu or call (765) 631-2108. You may also contact my Dissertation Committee Chair at Ball State University, Dr. Joseph Armstrong, Ph.D. at jarmstrong@bsu.edu or call (765)285-5475.

Thank you,

Lucy Tormoehlen

PS. I will make my research findings available to The Indiana Center for Parish Nursing.

Reminder Letter

From: Lucy Tormoehlen

To: _____

Subject: A Learning Needs Assessment of Parish Nurses

Dear Parish Nurse,

Just a quick reminder to have you complete my dissertation survey about the learning needs of novice Parish Nurses. If you have already completed this survey, I thank you and please disregard this notice.

The survey focuses on the learning needs of novice Parish Nurses during the time when a Parish Nurse ministry is being established. Registered nurses who have completed a Parish Nurse training course are asked to take the survey. Your participation and honest answers are crucial in assessing what are the most important skills needed in setting up a Parish Nurse ministry, what percentage of novice Parish Nurses are *deficient* in each skill, and what skills need added emphasis in the Parish Nurse training course. The study results will help in the training for Parish Nurses.

The survey takes about 15-30 minutes and is completely voluntary and anonymous. No personal identifiers will be used on the data, and no password is needed. You may withdraw anytime without penalty by clicking the X in the top right of the screen. To start the survey, click on the following link:

www.tLTgroup.org/Flashlight?FLO Please click "Send Survey" at the end to submit your responses.

This research has the approval of the Institutional Review Board from Ball State University. Completing this survey constitutes your consent, but if you have any questions or need help, you may contact me, Lucy Tormoehlen, at ltormoeh@iuk.edu or

call (765) 631-2108. You may also contact my Dissertation Committee Chair at Ball State University, Dr. Joseph Armstrong, Ph.D. at Jarmstrong@bsu.edu or call (765)285-5475.

Thank you,

Lucy Tormoehlen

PS. I will make my research findings available to The Indiana Center for Parish Nursing.

Appendix C: Content Validity

Content Validity Experts' Letter 1

Date: May16, 2008

To: RS, LW, SH, MB

Subject: Content Validity Questionnaire for my Dissertation Survey Instrument

Dear ____, I am writing to ask your assistance in achieving content validity for my dissertation survey instrument. I have prepared a list of Parish Nursing skills that have varying degrees of importance, only **ten** of which will be used for the participant survey. The study is designed to ascertain what Parish Nurses perceive as most important skills in starting up a Parish Nurse ministry, how deficient novice Parish Nurses are perceived to be for each skill, and for which skills should the Parish Nurse training course add more training.

A content validity index (CVI) score will be computed for each item, based on ratings of relevance from yourself and three other Parish Nursing experts. The CVI values will be the guide as to whether an item will be used as is, revised, or discarded. It may be necessary to ask you to give another set of ratings based on the first round revisions. The skill list needs to be reduced to ten since respondents will be answering thirty questions, (each skill has three questions). In the box at the end of the survey, your comments are welcomed regarding revising skills in this list or describing other Parish Nursing skills to be added to this list.

To take the survey click on <http://CTLSilhouette.wsu.edu/surveys/ZS79284>

Please be sure to click “Send Survey” at the end to submit your responses.

Thank you for your assistance. I will share my results at the conclusion of the study.

Sincerely,

Lucy Tormoehlen

Content Validity Experts' Survey 1
(2 pages)

Content Validity

Thank you for taking the time to answer this survey. Please remember to click "Send Survey" at the very end to enter your responses.

Please rate the skills by clicking on the radio button indicating the degree of relevance for each skill as it applies to a novice Parish Nurse setting up a Parish Nurse ministry.								
The Parish Nursing skill of	Click your choice here. Comments are at the end of the survey.							
	<table border="1"> <tr> <th>Highly relevant</th> <th>Quite relevant</th> <th>Somewhat relevant</th> <th>Not relevant</th> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Highly relevant	Quite relevant	Somewhat relevant	Not relevant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Highly relevant	Quite relevant	Somewhat relevant	Not relevant					
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
1.	working with the church clergy.							
2.	working with governing bodies in the church.							
3.	working with the health cabinet.							
4.	working with other organizations/committees in the church.							
5.	functioning in the organizational structure of the church. This includes the line of responsibility, reporting, and independence.							
6.	making an assessment of the church's health needs.							
7.	writing a job description that is used as a tool for evaluation.							
8.	educating the congregation in understanding the role of the Parish Nurse.							
9.	making out the Parish Nursing budget.							
10.	maintaining a documentation system.							
11.	maintaining confidentiality of everyone with whom the Parish Nurse works.							
12.	practicing good self care as a Parish Nurse.							
13.	providing health activities for the congregation							
14.	praying with others.							

15.	working with volunteers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	making an assessment of the community surrounding the church.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	writing policies and procedures for the Parish Nursing ministry.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	obtaining continuing education for the Parish Nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	utilizing local, regional, national, and denominational resources for the Parish Nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	providing spiritual care for members of the congregation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. Please enter comments about editing these skills or list other skills you feel are highly relevant.

Content Validity Results 1 – 2 pages



Survey Key: ZS79284












This is an anonymous survey.

The number of people who took this survey by 6/6/2008 11:11:37 AM is: 4

Content Validity

Thank you for taking the time to answer this survey. Please remember to click "Send Survey" at the very end to enter your responses.

Please rate the skills by clicking on the radio button indicating the degree of relevance for each skill as it applies to a novice Parish Nurse setting up a Parish Nurse ministry.		Click your choice here. Comments are at the end of the survey.				Composite Score
The Parish Nursing skill of		Highly relevant	Quite relevant	Somewhat relevant	Not relevant	
1.	working with the church clergy.	[1]	[3]	[0]	[0]	3.25
2.	working with governing bodies in the church.	[0]	[4]	[0]	[0]	3.0
3.	working with the health cabinet.	[0]	[3]	[1]	[0]	2.75
4.	working with other organizations/committees in the church.	[0]	[3]	[1]	[0]	2.75
5.	functioning in the organizational structure of the church. This includes the line of responsibility, reporting, and independence.	[3]	[1]	[0]	[0]	3.75
6.	making an assessment of the church's health needs.	[3]	[1]	[0]	[0]	3.75
7.	writing a job description that is used as a tool for evaluation.	[1]	[2]	[1]	[0]	3.0
8.	educating the congregation in understanding the role of the Parish Nurse.	[4]	[0]	[0]	[0]	4.0
9.	making out the Parish Nursing budget.	[1]	[3]	[0]	[0]	3.25

10.	maintaining a documentation system.		☺ [3]	☺ [0]	☺ [1]	☺ [0]	3.5
11.	maintaining confidentiality of everyone with whom the Parish Nurse works.		☺ [4]	☺ [0]	☺ [0]	☺ [0]	4.0
12.	practicing good self care as a Parish Nurse.		☺ [0]	☺ [3]	☺ [1]	☺ [0]	2.75
13.	providing health activities for the congregation.		☺ [3]	☺ [1]	☺ [0]	☺ [0]	3.75
14.	praying with others.		☺ [3]	☺ [1]	☺ [0]	☺ [0]	3.75
15.	working with volunteers.		☺ [2]	☺ [2]	☺ [0]	☺ [0]	3.0
16.	making an assessment of the community surrounding the church.		☺ [1]	☺ [1]	☺ [2]	☺ [0]	2.75
17.	writing policies and procedures for the Parish Nursing ministry.		☺ [0]	☺ [3]	☺ [1]	☺ [0]	2.75
18.	obtaining continuing education for the Parish Nurse.		☺ [0]	☺ [4]	☺ [0]	☺ [0]	3.0
19.	utilizing local, regional, national, and denominational resources for the Parish Nurse.		☺ [1]	☺ [3]	☺ [0]	☺ [0]	3.25
20.	providing spiritual care for members of the congregation.		☺ [2]	☺ [2]	☺ [0]	☺ [0]	3.5

21. Please enter comments about these skills or list other skills you feel are highly relevant.

[I think your items 1-4 have a lot of similarities, can you collapse them down? Also, in items 1-4, when you have "working with" I wonder if there might not be a better verb that captures the dynamic nature of the job.]

[Advocacy is essential and highly relevant, especially given the social and economic issues and problems in this nation at this time. I would suggest that when you write this report up you use a less biased term other than church - faith community is more inclusive.]

[responses based on my experience. The first 3 or 4 work together as do the job description and other documents. Suggest adding visibility and attendance at church and community activities. Could your skills be lined up with PN functions? Also important is having regular hours and office space. Good luck with the dissertation. Go Fish! Marilyn]

End of Survey

Content Validity Experts' Letter 2

From: Tormoehlen, Lucy J

Sent: Tuesday, May 27, 2008 11:36 AM

To:

Subject: RE: Content Validity Questionnaire 2nd cut

Dear _____, Thank you for your immediate response to the content validity questionnaire for my dissertation survey instrument. The list of Parish Nursing skills has been reduced to 15, but I am hoping to reduce it further to ten for the participant survey. Keep in mind that the survey will be a list the most important skills needed by the novice Parish Nurse in starting up a Parish Nurse ministry.

To take the survey click on <http://CTLSilhouette.wsu.edu/surveys/ZS79583>

Please be sure to click "Send Survey" at the end to submit your responses.

Thank you again for your assistance.

Sincerely,

Lucy Tormoehlen

Content Validity Experts' Survey 2 2

Content Validity - 2nd cut Print Friendly Preview

Page 1 of 1

Content Validity - 2nd cut

Thank you for taking the time to answer this survey. Please remember to click "Send Survey" at the very end to enter your responses.

Please rate the skills by clicking on the radio button indicating the degree of relevance for each skill as it applies to a novice Parish Nurse setting up a Parish Nurse ministry.					
The Parish Nursing skill of		Click your choice here. Comments are at the end of the survey.			
		Highly relevant	Quite relevant	Somewhat relevant	Not relevant
1.	working with the church clergy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	working with governing bodies in the church.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	functioning in the organizational structure of the church. This includes the line of responsibility, reporting, and independence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	making an assessment of the church's health needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	writing a job description that is used as a tool for evaluation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	educating the congregation in understanding the role of the Parish Nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	making out the Parish Nursing budget.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	maintaining a documentation system.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	maintaining confidentiality of everyone with whom the Parish Nurse works.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	providing health activities for the congregation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11.	praying with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	working with volunteers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	obtaining continuing education for the Parish Nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	utilizing local, regional, national, and denominational resources for the Parish Nurse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	providing spiritual care for members of the congregation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. Please enter comments about editing these skills or list other skills you feel are highly relevant.

Content Validity Results 2 – 2 pages



Survey Key: ZS79583































This is an anonymous survey.

The number of people who took this survey by 6/6/2008 11:32:20 AM is: 3

Content Validity - 2nd cut

Thank you for taking the time to answer this survey. Please remember to click "Send Survey" at the very end to enter your responses.

Please rate the skills by clicking on the radio button indicating the degree of relevance for each skill as it applies to a novice Parish Nurse setting up a Parish Nurse ministry.						
The Parish Nursing skill of						
Click your choice here. Comments are at the end of the survey.						
		Highly relevant	Quite relevant	Somewhat relevant	Not relevant	Composite Score
1. working with the church clergy.		<input type="radio"/> [1]	<input type="radio"/> [1]	<input type="radio"/> [0]	<input type="radio"/> [0]	2.33
2. working with governing bodies in the church.		<input type="radio"/> [0]	<input type="radio"/> [2]	<input type="radio"/> [0]	<input type="radio"/> [0]	2.0
3. functioning in the organizational structure of the church. This includes the line of responsibility, reporting, and independence.		<input type="radio"/> [2]	<input type="radio"/> [1]	<input type="radio"/> [0]	<input type="radio"/> [0]	3.67
4. making an assessment of the church's health needs.		<input type="radio"/> [1]	<input type="radio"/> [2]	<input type="radio"/> [0]	<input type="radio"/> [0]	3.33
5. writing a job description that is used as a tool for evaluation.		<input type="radio"/> [1]	<input type="radio"/> [0]	<input type="radio"/> [1]	<input type="radio"/> [0]	2.0
6. educating the congregation in understanding the role of the Parish Nurse.		<input type="radio"/> [1]	<input type="radio"/> [2]	<input type="radio"/> [0]	<input type="radio"/> [0]	3.33
7. making out the Parish Nursing budget.		<input type="radio"/> [2]	<input type="radio"/> [1]	<input type="radio"/> [0]	<input type="radio"/> [0]	3.67
8. maintaining a documentation system.		<input type="radio"/> [2]	<input type="radio"/> [0]	<input type="radio"/> [1]	<input type="radio"/> [0]	3.33
9. maintaining confidentiality of everyone with whom the Parish Nurse works.		<input type="radio"/> [2]	<input type="radio"/> [1]	<input type="radio"/> [0]	<input type="radio"/> [0]	3.67

10.	providing health activities for the congregation.		 [0]	 [3]	 [0]	 [0]	3.0
11.	praying with others.		 [0]	 [3]	 [0]	 [0]	3.0
12.	working with volunteers.		 [1]	 [1]	 [1]	 [0]	3.0
13.	obtaining continuing education for the Parish Nurse.		 [0]	 [2]	 [1]	 [0]	2.67
14.	utilizing local, regional, national, and denominational resources for the Parish Nurse.		 [1]	 [2]	 [0]	 [0]	3.33
15.	providing spiritual care for members of the congregation.		 [1]	 [1]	 [1]	 [0]	3.0

16. Please enter comments about editing these skills or list other skills you feel are highly relevant.

[I think that praying with others could easily become a part of the providing spiritual care for members of the congregation choice. I would also suggest using the term faith community rather than church so that your survey is more inclusive - leads to higher return rate. I think that organizational structure and politics could encompass choice numbers 1, 2, and 3.]

[First three skills could be combined. #3 would cover working within the organization.]

End of Survey

Appendix D: The Survey
(11 pages)

A Learning Needs Assessment of Parish Nurses

Items 1-5 are demographic information. Questions 6 to 50 are your opinions about the Parish Nursing skills of novice Parish Nurses. Your answers should apply to the time span of the first year when the novice Parish Nurse is attempting to establish a Parish Nurse ministry following the completion of a basic Parish Nursing course. Note: 'church' is synonymous with any faith community; 'congregation' is synonymous with members of any faith community. A comment box is included for each skill and your comments and feelings are welcome.

1. The year I completed a basic Parish Nursing course is

2. My religious denomination is

3. My age range is

- ☐ 25 or less
- ☐ 26 - 35
- ☐ 36 - 45
- ☐ 46 - 55
- ☐ 56 - 65
- ☐ more than 65

4. The highest health care related degree I have completed is

- ☐ Associates
- ☐ Diploma
- ☐ Baccalaureate
- ☐ Masters
- ☐ Doctorate

5. I have served as an active Parish Nurse for _____ years.

6. How important do you feel is the Parish Nursing skill of functioning in the organizational

structure of the church? This includes the line of responsibility, reporting, and independence.

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

7. What percentage of novice Parish Nurses do you feel are deficient in the skill of functioning in the organizational structure of the church?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

8. How important is it for the Parish Nurse course to add more training in the skill of functioning in the organizational structure of the church?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

9. Comments about the Parish Nursing skill of functioning in the organizational structure of the church.

10. How important do you feel is the Parish Nursing skill of making an assessment of the church's health needs?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important

☐ Not important

11. What percentage of novice Parish Nurses do you feel are deficient in the skill of making an assessment of the church's health needs?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

12. How important is it for the Parish Nurse course to add more training in the skill of making an assessment of the church's health needs?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

13. Comments about the Parish Nursing skill of making an assessment of the church's health needs.

14. How important do you feel is the Parish Nursing skill of educating the congregation in understanding the role of the Parish Nurse?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

15. What percentage of novice Parish Nurses do you feel are deficient in the skill of educating the congregation in understanding the role of the Parish Nurse?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%

- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

16. How important is it for the Parish Nurse course to add more training in the skill of educating the congregation in understanding the role of the Parish Nurse?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

17. Comments about the Parish Nursing skill of educating the congregation in understanding the role of the Parish Nurse.

18. How important do you feel is the Parish Nursing skill of making out the Parish Nursing budget?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

19. What percentage of novice Parish Nurses do you feel are deficient in the skill of making out the Parish Nursing budget?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

20. How important is it for the Parish Nurse course to add more training in the skill of making out the Parish Nursing budget?

- ☐ Of utmost importance

- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

21. Comments about the skill of making out a Parish Nursing budget.

22. How important do you feel is the Parish Nursing skill of maintaining a documentation system?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

23. What percentage of novice Parish Nurses do you feel are deficient in the skill of maintaining a documentation system?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

24. How important is it for the Parish Nurse course to add more training in the skill of maintaining a documentation system?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

25. Comments about the Parish Nursing skill of maintaining a documentation system.

26. How important do you feel is the Parish Nursing skill of maintaining the confidentiality of everyone with whom the Parish Nurse works?
- ☐ Of utmost importance
 - ☐ Highly important
 - ☐ Moderately important
 - ☐ Somewhat important
 - ☐ Less important
 - ☐ Not important
27. What percentage of novice Parish Nurses do you feel are deficient in the skill of maintaining the confidentiality of everyone with whom the Parish Nurse works?
- ☐ Less than 50%
 - ☐ 50 - 59%
 - ☐ 60 - 69%
 - ☐ 70 - 79%
 - ☐ 80 - 89%
 - ☐ 90 - 100%
28. How important is it for the Parish Nurse course to add more training in the skill of maintaining the confidentiality of everyone with whom the Parish Nurse works?
- ☐ Of utmost importance
 - ☐ Highly important
 - ☐ Moderately important
 - ☐ Somewhat important
 - ☐ Less important
 - ☐ Not important
29. Comments about the Parish Nursing skill of maintaining the confidentiality of everyone with whom the Parish Nurse works.
-
30. How important do you feel is the Parish Nursing skill of providing health activities for the congregation?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

31. What percentage of novice Parish Nurses do you feel are deficient in the skill of providing health activities for the congregation?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

32. How important is it for the Parish Nurse course to add more training in the skill of providing health activities for the congregation?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

33. Comments about the Parish Nursing skill of providing health activities for the congregation.

34. How important do you feel is the Parish Nursing skill of praying with others?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

35. What percentage of novice Parish Nurses do you feel are deficient in the skill of praying with others?
- ☐ Less than 50%
 - ☐ 50 - 59%
 - ☐ 60 - 69%
 - ☐ 70 - 79%
 - ☐ 80 - 89%
 - ☐ 90 - 100%
36. How important is it for the Parish Nurse course to add more training in the skill of praying with others?
- ☐ Of utmost importance
 - ☐ Highly important
 - ☐ Moderately important
 - ☐ Somewhat important
 - ☐ Less important
 - ☐ Not important
37. Comments about the Parish Nursing skill of praying with others.
-
38. How important do you feel is the Parish Nursing skill of working with volunteers?
- ☐ Of utmost importance
 - ☐ Highly important
 - ☐ Moderately important
 - ☐ Somewhat important
 - ☐ Less important
 - ☐ Not important
39. What percentage of novice Parish Nurses do you feel are deficient in the skill of working with volunteers?
- ☐ Less than 50%
 - ☐ 50 - 59%
 - ☐ 60 - 69%
 - ☐ 70 - 79%
 - ☐ 80 - 89%
 - ☐ 90 - 100%

40. How important is it for the Parish Nurse course to add more training in the skill of working with volunteers?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

41. Comments about the Parish Nursing skill of working with volunteers.

42. How important do you feel is the Parish Nursing skill of utilizing local, regional, national, and denominational resources for the Parish Nurse?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

43. What percentage of novice Parish Nurses do you feel are deficient in the skill of utilizing local, regional, national, and denominational resources for the Parish Nurse?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

44. How important is it for the Parish Nurse course to add more training in the skill of utilizing local, regional, national, and denominational resources for the Parish Nurse?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important

☐ Not important

45. Comments about the Parish Nursing skill of utilizing local, regional, national, and denominational resources for the Parish Nurse.

46. How important do you feel is the Parish Nursing skill of providing spiritual care for members of the congregation?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

47. What percentage of novice Parish Nurses do you feel are deficient in the skill of providing spiritual care for members of the congregation?

- ☐ Less than 50%
- ☐ 50 - 59%
- ☐ 60 - 69%
- ☐ 70 - 79%
- ☐ 80 - 89%
- ☐ 90 - 100%

48. How important is it for the Parish Nurse course to add more training in the skill of providing spiritual care for members of the congregation?

- ☐ Of utmost importance
- ☐ Highly important
- ☐ Moderately important
- ☐ Somewhat important
- ☐ Less important
- ☐ Not important

49. Comments about the Parish Nursing skill of providing spiritual care for members of the congregation.

50. Comments about other important Parish Nursing skills.

Appendix E: Using Flashlight

Security of Flashlight Online

This information is taken from Flashlight Frequently Asked Questions (FAQs) accessible at <http://www.tltgroup.org/Flashlight/FAQs.htm#17.%20I%20have%20a%20question%20about%20using%20Flashlight%20Online>

18. How secure is Flashlight Online?

No one from another institution can see your surveys unless you give them authorization to be in a "member group" that is under your local administrative group.

Only the author of a survey (the person who started the survey), or someone else that the author explicitly designates, can download the raw data at any time.

Recently Charles Ansorge of the University of Nebraska wrote, "I submitted an IRB (Institutional Review Board) proposal using a Flashlight Survey as the tool and they want to know whether the data will be sent to a secure server, whether the data will be encrypted while in transit, and will it collect IP addresses?"

We replied:

1. Secure server? — Yes, we take every measure to protect the security of the data on our server. It is behind a secure firewall and all security updates are applied to the server in a timely fashion. It is also physically secured in the server room which includes video surveillance.
2. Encrypted in transit? — No, we do not encrypt data passed in transit.
3. Collect IP numbers? — While no IP numbers are stored with the survey responses we do collect IP numbers in the server log. The server log is replaced on a rotation schedule and there is no link that can definitely be made between any respondent and the IP number they took the survey from. If a survey has

respondent IDs this is also the case. Those IDs are in no way tied to the server log of IP numbers.

Data Stored at Flashlight (2 pages)

From: Matt Gordon [mailto:gordon@tlgroup.org]
Sent: Thursday, May 22, 2008 4:49 PM
To: Tormoehlen, Lucy J
Subject: RE: Is survey data destroyed?

Hi Lucy,

I hope this answers your questions:

Where will the data be stored?

All data is stored at Washington State University

How long they will be retained?

All data is stored indefinitely.

Who will have access to the data?

The survey author is the only one who has access to the data.

When will data be destroyed?

All data is stored indefinitely.

If you need additional information, please let me know.

Matt

Matthew Gordon
Subscription Coordinator
Phone: 323.251.2147
gordon@tlgroup.org
www.tlgroup.org

~~~~~

**From:** Tormoehlen, Lucy J [mailto:ltormoeh@iuk.edu]  
**Sent:** Thursday, May 22, 2008 4:12 PM  
**To:** Matt Gordon  
**Subject:** Is survey data destroyed?

I am preparing a narrative description of my study for the Institutional Review

Board at Ball State University and the Guidelines for this document require: *Also*

*indicate where the data will be stored, how long they will be retained, who will have access to the data, and when/how data will be destroyed.*

I understand that un-started surveys can be deleted by the author, but FAQ's lead me to believe that any started or started and stopped surveys are not delete-able. If so, is or will the study data ever be destroyed? I know it is author protected, but how should I answer the IRB statement?

Thank you

Lucy Tormoehlen

Indiana University Kokomo

## Appendix F: Certificate of Human Participant Protections Education for Research

Blackboard Learning System TM (Release 6)

http://my.bsu.edu/webapps/portal/frameset.jsp?tab=courses&url=/bin/common/course... Google

@myBSU Courses Community Bb Res - Students Student Res Web Mail


Announcements  
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Course Documents  
Communication  
Discussion Board  
External Links  
Tools

Course Map

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U.S. National Institutes of Health www.cancer.gov

Search  GO

NCI Home **Cancer Topics** Clinical Trials Cancer Statistics Research & Funding News About NCI

 **Human Participant Protections Education for Research Teams**

**Completion Certificate**

This is to certify that

**Lucy Tormoehlen**

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 09/06/2005.



This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

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